



Midwifery and child health nursing: supporting early parenting mental wellbeing

Robyn Gail Kelly RN RM CHN
BA, BEd, BN, Grad. Dip. (Midwifery) Grad. Cert. (Child Health) MIH

Submitted in fulfilment of the requirements for
the degree of Doctor of Philosophy

**Tasmanian Institute of Learning and Teaching
University of Tasmania**

June 2014

Declaration of Originality

I, Robyn Gail Kelly, am the author of the thesis titled Midwifery and child health nursing: supporting early parenting mental wellbeing, submitted for the degree of Doctor of Philosophy. I declare that the material is original, and to the best of my knowledge and belief, contains no material previously published or written by another person, except where due acknowledgement is made in the text of the thesis, nor does the thesis contain any material that infringes copyright. The thesis contains no material which has been accepted for a degree or diploma by the University or any other institution.

Authority of Access

I, Robyn Gail Kelly, author of the thesis titled Midwifery and child health nursing: supporting early parenting mental wellbeing, submitted for the degree of Doctor of Philosophy, agree that this thesis may be made available for loan and limited copying and communication in accordance with the Copyright Act 1968.

Statement of Ethical Conduct

The research associated with this thesis abides by the international and Australian codes on human research and was approved by The Tasmanian Health and Medical Human Research Ethics Committee (reference number: H0011516).

Robyn Gail Kelly

June 2014

Acknowledgements

At times our own light goes out and is rekindled by a spark from another person. Each of us has cause to think with deep gratitude of those who have re lit the flame within us.'

Albert Schweitzer

From the cafes in Floreat, Western Australia to the cafes in Launceston and Sheffield, Tasmania, I have been extremely fortunate to have enjoyed strong, collegial (and good coffee and good food oriented) friendships with both my supervisors throughout my candidature. I have been wonderfully and fully supported by these two people – one a midwife, one a teacher - throughout my journey.

Firstly, Professor Yvonne Hauck has been my mentor in research since my undergraduate nursing degree in Western Australia, through to sharing child health nursing research endeavours, collegial guidance during my Masters in International Health in Perth and now, as an Associate Supervisor in my PhD candidature. Regardless of geographical distance in this last role, I thank her for her inspiring support over the PhD candidacy. I have valued greatly her gentle and steady motivating presence and breadth of midwifery knowledge throughout and I look forward to more collaboration and coffee at Delish in my future visits back home.

Dr Sharon Thomas was ensconced early in my PhD journey as ‘co-conspirator’ at many breakfasts of eggs benedict and ‘very hot’ lattes in Launceston, where she encouraged me immeasurably in my beginning stages. As time went on, she became a consultant in my supervisory team due to her teaching scholarship capacity and as acknowledgement of her input into my earlier ‘musings’. She then took up the not inconsiderable reigns of Primary Supervisor in the last year of my candidature. Her support has been an epicurean and scholarly journey of immense proportions. I thank her very much for her strong commitment in both time and effort to my research journey from inception to end. I have valued her tenacity, sense of humour, encouragement and have been inspired by her breadth of learning and teaching scholarship. I also look forward to more collegial collaboration with her and to many more breakfasts.

I would also like to acknowledge the support of Professor Denise Fassett, who, in her role of Primary Supervisor supported me in the initial development and intermediate data collection stages of this thesis. Professor Fassett accepted the position of Dean, Faculty of Health at the beginning of January 2013 and stepped down from role of supervisor due to increased work commitments.

Collegial friendships at the University of Tasmania have played a significant part in my PhD journey and many strong and rigorous debates have taken place in academic corridors, at conferences, and of course, over breakfasts, lunches and dinners.

Specifically, I thank Dr Lindsay Smith and Dr David Lees for their support with reading through areas of my thesis and for their encouragement in countless discussions. However, in particular, I would like to acknowledge the support and advice of my colleague Geoff Crack. I would like to thank him for his many suggestions and his reading of the final thesis. Specifically, I recognise him for his breadth of academic knowledge of and zeal for Primary Health Care that he unreservedly shares, which contributed to my passion for health promotion.

Thank you to all colleagues named and unnamed who have helped me considerably in this journey.

I also thank Michelle Hatchett for the shaping and formatting of this thesis.

Finally I would like to thank the midwives and child health nurses who took part in this study for their candid and considered comments regarding this important construct in early parenting.

There exist natural forces that oppose the attraction between the large medically focussed and treatment oriented constellation, and the smaller community health oriented one – professional competitiveness, differences in understanding of what health means, competition for political attention and for funding. At the Helsinki conference, one vocal mental health advocate called for a stop to professional jealousy, unfathomable bickering and territory defending, loosening one of the Conference's few spontaneous bursts of enthusiastic applause. But as applause does, it quickly exhausted itself. At this conference, dominated by the larger constellation, the term 'mental health promotion' was used mostly as a euphemism for mental disorder prevention. And the conversational agenda of the mental disorder constellation was stoutly defended and clearly dominant.

Maurice Mittelmark 2005

If researchers study only family problems, they are likely to find only family problems. Similarly, if educators, community organisers, therapists and researchers are interested in family strengths, they look for them. When these strengths are identified, they can become the foundation for continued growth and positive change in a family and a society.

John DeFrain 2000

Abstract

Midwifery and child health nursing: supporting early parenting mental wellbeing

Background:

Midwives and child health nurses are the key providers of perinatal education to families. There is little research internationally that documents how these health professionals deliver and families obtain mental health promotion, as opposed to screening for mental illness, within the perinatal education arena.

Aim:

This PhD study critically analyses how early parenting mental health promotion is understood and implemented by midwives and child health nurses in early parenting services in the state of Tasmania, Australia.

Method:

A critical ethnographical study by an Australian registered midwife and child health nurse in which 13 public hospital registered midwives and 18 community child health nurses were interviewed in 2011-2012 using approximately hour long, semi-structured and co-constructed strategies. The interviews explored these health professionals' understanding and practice of mental health promotion and how the two services implemented this promotion. State-wide documents from these services pertaining to perinatal curricula, protocols and policies for parenting information were also collated in 2012 and 2013 and then analysed for mental health promotional content.

Key Findings:

Analysis of interviews and documents concluded contested understandings of mental health promotion and implementation in practice. Three key findings were: 1) mental health promotion was complex to understand and complex to implement, 2) mental health promotion was represented in perinatal educational practice as early detection and prevention of perinatal depression, and 3) there was a plethora of constraints within the Women's and Children's Services (WACS) and Child Health and Parenting Service (CHAPS) that made detecting and preventing perinatal depression difficult and promoting mental health almost impossible.

Overall, current practices of delivering care – specifically current policies and management strategies and practices – were clear barriers to supporting families in this significant area that contributes to the wellbeing of parent and baby.

Implications for midwifery and child health nursing practice and policy:

The implementation of mental health promotion is gaining ascendancy internationally; these findings around how mental health promotion, as opposed to early detection and prevention of mental illness, is perceived and implemented by key parenting supporters are particularly timely for informing future perinatal parenting service policy and provision.

Table of Contents

Declaration of Originality	ii
Authority of Access	ii
Statement of Ethical Conduct	ii
Acknowledgements	iii
Abstract – Midwifery and child health nursing: supporting early parenting mental wellbeing	vi
Table of Contents	viii
Preface	xiii

Chapter 1 Introduction and Overview	1
1.1 Introduction	1
1.2 A study about mental health promotion in early parenting	1
1.3 The significance of mental health promotion in early parenting	4
1.3.1 <i>Burden of postnatal depression to families and society</i>	4
1.3.2 <i>Manifold benefits of staying mentally well</i>	7
1.3.3 <i>Strengths-based approaches to family nursing</i>	8
1.3.4 <i>Neurodevelopment in infancy</i>	9
1.3.5 <i>Summary</i>	9
1.4 Approach	10
1.5 Researcher voice	11
1.6 Context	11
1.6.1 <i>Place – Tasmania</i>	12
1.6.2 <i>Setting</i>	13
1.7 Thesis overview	14
Chapter 2 Literature Review	17
2.1 Introduction	17
2.2 Search Methodology	17
2.3 Defining terms	19
2.3.1 <i>Health promotion and mental health promotion</i>	19
2.3.2 <i>Parenting and parenting education</i>	20
2.4 Literature review outline	20
2.5 Postnatal Depression	21

2.6	Parenting education classes	23
2.6.1	<i>Antenatal or before birth classes</i>	23
2.6.2	<i>Antenatal (perinatal) classes today</i>	28
2.6.3	<i>Development of child health nursing and parenting education</i>	30
2.6.4	<i>Child health nursing and anticipatory guidance today</i>	31
2.6.5	<i>Summary</i>	32
2.7	Mental health promotion in parenting education	33
2.7.1	<i>Health Promotion</i>	34
2.7.2	<i>From health promotion to mental health promotion</i>	36
2.7.3	<i>Current mental health promotion in midwifery-led parenting education</i>	37
2.7.4	<i>Current mental health promotion in child health nursing-led parenting education</i>	40
2.8	Conclusion	41
	Chapter 3 Methodology	42
3.1	Introduction	42
3.2	Methodology	42
3.2.1	<i>Positioning this study within a research paradigm</i>	44
3.2.2	<i>Research question</i>	45
3.2.3	<i>Ethnographical approach</i>	46
3.2.4	<i>Critical ethnography</i>	47
3.3	Method	49
3.3.1	<i>Interviewing</i>	50
3.3.2	<i>Interview process</i>	51
3.3.3	<i>Interview co-construction and mutualistic relationship</i>	54
3.3.4	<i>Interview recruitment</i>	55
3.3.5	<i>Documents process</i>	56
3.4	Coordinating the data	57
3.4.1	<i>Recordings</i>	57
3.4.2	<i>Documents</i>	57
3.4.3	<i>Notes and memos</i>	58

3.5	Analysing the data	59
3.5.1	<i>Interview analysis process</i>	59
3.5.2	<i>Document content analysis process</i>	63
3.5.3	<i>Memos and notes</i>	67
3.6	Reflexivity	67
3.6.1	<i>Formation of interview questions</i>	69
3.7	Conclusion	76
Chapter 4	Findings and discussion: Complex understandings of mental health	80
4.1	Introduction	81
4.2	Defining mental health	81
4.2.1	<i>Consternation</i>	82
4.2.2	<i>Confusion</i>	82
4.2.3	<i>Discussion</i>	84
4.2.4	<i>Summary of defining mental health</i>	88
4.3	The complexity of mental health promotion definitions in practice	88
4.3.1	<i>Screening</i>	89
4.3.2	<i>Raising awareness</i>	90
4.3.3	<i>Perinatal depression awareness</i>	91
4.3.4	<i>Discussion</i>	92
4.3.5	<i>Summary regarding the complexity of mental health promotion in practice</i>	96
4.4	Explaining the complexity of mental health promotion	97
4.4.1	<i>Stigma of mental illness</i>	98
4.4.2	<i>The complex scope of mental health</i>	99
4.4.3	<i>Discussion</i>	101
4.4.4	<i>Summary of explaining the complexity of mental health promotion</i>	103
4.5	Conclusion	103
Chapter 5	Findings and discussion: Default mental illness framework	105
5.1	Introduction	106
5.2	Participant practice embedded in an illness framework	108
5.2.1	<i>Risk factors</i>	109
5.2.2	<i>(Mental) health promotion</i>	110
5.2.3	<i>Knowledge construction of mental health promotion</i>	111

5.2.4	<i>Workplace structure</i>	111
5.2.5	<i>Discussion</i>	113
5.2.6	<i>Summary of being embedded within a mental illness framework</i>	118
5.3	Policies and protocols embedded in mental illness framework	119
5.3.1	<i>Anticipatory guidance</i>	121
5.3.2	<i>Family/psychosocial assessment</i>	123
5.3.3	<i>Edinburgh Postnatal Depression Scale (EDPS) screening</i>	127
5.3.4	<i>Perinatal depression resources</i>	129
5.3.5	<i>ObstetriX database (midwifery)</i>	130
5.3.6	<i>Child health surveillance</i>	131
5.3.7	<i>Antenatal parenting classes</i>	133
5.3.8	<i>Discussion</i>	135
5.3.9	<i>Summary of the subtheme regarding policies and protocols embedded in a mental illness framework</i>	141
5.4	Conclusion	141
Chapter 6 Findings and discussion: Barriers to mental health promotion		143
6.1	Introduction	144
6.2	Inadequate communication	146
6.2.1	<i>Barriers to therapeutic relationship building</i>	146
6.2.2	<i>Barriers to communicating with parents</i>	150
6.2.3	<i>Discussion</i>	153
6.2.4	<i>Summary to subtheme barrier of inadequate communication</i>	157
6.3	Inadequate time	157
6.3.1	<i>Discussion</i>	161
6.3.2	<i>Summary of subtheme of inadequate time</i>	163
6.4	Medical influence	163
6.4.1	<i>Discussion</i>	166
6.4.2	<i>Summary of the subtheme of the barrier of medical influence</i>	168
6.5	Incongruent delivery of care	168
6.5.1	<i>Workforce barriers</i>	169
6.5.2	<i>Target platform</i>	171
6.5.3	<i>Inadequate funding</i>	174

6.5.4	<i>Workplace structural barriers</i>	177
6.5.5	<i>Acute care practice</i>	182
6.5.6	<i>Discussion</i>	183
6.5.7	<i>Summary of subtheme regarding an incongruence of models of care as a barrier to mental health promotion</i>	189
6.6	Conclusion	191
Chapter 7 Serving the interests of parents in mental health promotion?		193
7.1	Conclusion	193
7.1.1	<i>Summary of findings</i>	194
7.2	Dusting of snow at the very top of the mountains	204
Chapter 8 References		206
Appendix 1 Letters of Support		243
Appendix 2 Ethics application approval letter		247
Appendix 3 a) Participant information letter		249
b) Participant information consent form		251
List of Tables		
Table 1	Consequences of maternal depression (Bernard-Bonin 2004, p.576)	6
Table 2	Layout of Findings/Discussions Chapters	76

Preface

“Critical ethnographers celebrate their normative and political positioning as a means of invoking social consciousness and societal change”.

(Thomas 1993 p.4)

Injustice diminishes us all. I recognise that I have thought this for most of my life as the passion to understand and overcome injustice was planted and nurtured in me, early in my life and continues to be a major motivator in both my personal and professional lives. This study is the culmination of many years of observing people around me, family, friends and parents as clients and seeing how they responded to and, in some instances, overcame mounting challenges in their lives. The most impressionable injustices have taken many forms from railing against the loss of a child, depression, alienation, relationship breakdown and bullying, to societal and economic influences of unemployment, violence and corruption. From an early age as a child of the 1960s, I watched the world around me and asked the questions ‘what is this?’ and ‘why is it like this?’ and when I could see a way to resolve an issue, I tried to ensure ‘it didn’t have to be this way’.

Never more so has this journey to overcome injustice been more formidable, than when it has occupied ‘the halls of power’ of government and institutions charged to support vulnerable consumers. I am female, a high school teacher, a midwife, a child health nurse and a nurse academic, and when marginalisation, funding and structural changes have impacted upon student learning and a person’s health, I have found the frustration of working within these systems almost unbearable. I moved into academia for the sole purpose of being able to complete health research that would have an impact upon the lives of vulnerable health consumers. My aim was to complete research that would overcome structural and organisation requirements that would be evidence-based and therefore compel implementation for change.

Never more so has this journey to overcome injustice been more heart rending than when it involved people in my working life who were suffering mental anguish, and in particular, parents with infants and young children. In my most recent clinical work, as a child health nurse, I wanted to understand what this parenting anguish was. Why were they suffering? Surely, it didn’t have to be this way? I felt compelled to make a difference and considered that health research would provide an avenue to make this difference.

Chapter 1

Introduction and Overview

1.1 Introduction

This critical ethnographical study focuses on a gap in evidence regarding how mental health promotion is understood and implemented in parenting education by Tasmanian hospital midwives and child health nurses who work in the community setting: key providers of perinatal parenting education. Through *this study's aim of exploring mental health promotion in perinatal education*, this study contributes original knowledge in understanding how mental health promotion is constructed by midwives and child health nurses and the perceived supports and barriers to its implementation within the two services. In doing so, this study examines whether the interests of parents' mental health promotion are being served in parenting perinatal education.

This introductory chapter briefly presents a professional reflection on the steps that led to researching mental health promotion in early parenting (conception through to first year after birth) education. Next, the significance of the construct of mental health promotion is argued in order to locate the catalyst for this study. Following this is a brief discussion about the methodological approach taken for this study and about researcher voice. Finally, a description of the study's context: its setting and participants is given, together with an outline of the remainder of the thesis. In structuring Chapter One this way, an overview of the 'what, how and why' of this thesis is given.

1.2 A study about mental health promotion in early parenting

My professional journey to this thesis began in my role as a child health nurse from 2001-2006, during which time I worked in partnership with parents at Ngala Family Resource Centre, a parenting organisation in Western Australia. Some parents who

visited the centre were suffering deeply due to new responsibilities, the vulnerability of an infant, lack of supports, and extreme fatigue; some due to a lack of hope. Yet others, in similar circumstances, were not suffering as deeply as others. Moreover, other parents were laughing and enjoying their new role, despite the adversity, requiring only some anticipatory guidance. All parents were eventually able to laugh. However, I reflected frequently whether those who were in anguish needed to suffer in the first place.

In brief, some parents were ‘breezing through’ the initial year of parenting. Others were experiencing the time as inherently stressful and were labelling it a crisis. In trying to make sense of this, I sought to understand more about this suffering in the parenting period and researched the literature on postnatal depression (PND), mental health prevention and promotion. I wanted to know whether the answers to the differing parental responses to having a child, lay in the ‘makeup’ of the parents themselves, the circumstances surrounding the perinatal period, in the way the parents approached parenting within this period, in all of the above, or in something else yet unknown.

From my studies and experience in midwifery and child health, I already understood a number of things. I understood that PND, or as Beck (1999) entitled it ‘a thief that steals motherhood’, was claiming the emotional lives of around one in five mothers and some one in ten fathers (O’Hara & Swain, 1996). I understood that my resident state, at that time Western Australia, had commenced screening maternity clients with the Edinburgh Postnatal Depression Scale (EPDS) both antenatally and postnatally by midwives and up to the first year of life post birth by child health nurses. I understood that this was performed in an effort to find those at risk of developing the illness and thus to embed supportive structures. I also understood that parents were given information about PND by both services; signs to watch out for and details of those to contact, if they were concerned. However, what I didn’t understand or, more accurately, what I couldn’t find, was information that could be used in perinatal education in order to promote staying mentally healthy. I found very valuable information regarding early detection and screening for risk and treatment, and some preventative interventions based on decreasing risk factors, yet little that discussed how ‘to flourish’ in the perinatal period.

Around this time, in my child health role at Ngala, I was introduced to a communication framework of ‘Working in Partnership with Parents’ (Davis, Day & Bidmead 2002) that supported techniques of nurse-parent engagement. At the same time, a strengths-based approach to parenting for clinicians, based on the work of DeFrain and Olsen (2000) was presented in a number of workshops by the Family Action Centre from Newcastle, Australia. These two influences on my communication with parents reinforced a need to establish where exactly a strength-based approach fitted within PND development or prevention. My premise was that I didn’t want parents to suffer in the first place and so I was left wondering where the actual promotion through education of staying well – one that incorporated a strengths-based approach as opposed to early detection or prevention of PND – could occur.

Through my continued research efforts, I began to understand that, at the time (2001-2006), mental health promotion was in its infancy and, above all, there was much confusion to confound health professionals regarding terminology: health promotion, mental health promotion, mental health, and mental illness (WHO 2005). On the whole, prevention was predicated mainly upon risk factor identification (i.e. a deficit model) and thus prevention of risks. Promotion was described as supporting protective factors (NHMRC 2008) but was still based on the same risk reduction model (Mazrak & Geraghty 1994) and aetiological and treatment research (Barry 2001). Child health nursing was also in its infancy regarding a strengths-based approach and how this strengths framework related to promotion of mental health was not directly acknowledged.

Currently, when I reflect on that time and on the current situation, I understand that it is only recently that the ascension of mental health promotion has taken place (Keyes, 2007; Jane-Llopis, 2005) and that strengths-based approaches have become embedded within nursing practices, particularly in family health and adolescent health (DeFrain & Asay 2007; Duncan et al. 2007). Finally, even though health promotion as a construct became more embedded within nursing practice from the mid-1970s and 1980s onwards with Primary Health Care and its initial implementation through the Ottawa Charter (WHO, CPHA 1986), *mental* health promotion seems to have lagged behind. It could be suggested that this was a direct

reflection of the late recognition and acknowledgement of mental illness and its significant burden to emotional lives lost.

1.3 The significance of mental health promotion in early parenting

In this next section I briefly present the significance for studying mental health promotion in early parenting (conception through to the first year post birth). I argue that this significance is in four main areas. The first of these is the burden of suffering that PND brings to parents, children, families, communities and to the wider society. The second is the manifold benefits to parents, children, families and communities of staying mentally well throughout the perinatal period and beyond. The third reason is the recognition of embracing a strengths-based orientation and the fourth, growing recognition of evidence that examines the role of neural pathway development in infancy and childhood. Reasons three and four have emerging significance in mental health promotion in early parenting.

In discussing these four areas of consequence, the imperative of embedding mental health promotion in midwifery-led and child health nursing perinatal education is highlighted.

1.3.1 *Burden of postnatal depression to families and society*

“The total number of people with perinatal depression in Australia in 2012 was estimated to be 96,156, including 71,177 new mothers and 24,979 new fathers”

(Post and Ante Natal Depression Association, PANDA 2013)

Postnatal depression is the most prevalent mood disorder associated with childbirth (NHMRC 2008 p.9). Notably, one in five Australian mothers of children aged 24 months or less are diagnosed with depression with more than half of these cases being reported within the perinatal period (AIHW, 2012 p.vi). Globally, the average prevalence rate of this postnatal mood disorder has been assessed at around 13-14 per cent (O’Hara & Swain, 1996; Halbreich & Karkun, 2006). However, MacLennan, Wilson, and Taylor (1996) report that only 49 per cent of mothers who feel seriously

depressed seek help, implying that the number could well be significantly higher (p.575).

The significance of PND is inherently related to the issue of vulnerability. Postnatal depression occurs at a time when a baby is at its most susceptible and most dependent upon another's care. As the illness occurs in the first few months after birth, it is associated with notable impairments in maternal interactions with the infant: detached, angry, and rejecting behaviours, as well as less parental involvement and poorer communications (Chiariello & Orvaschel, 1995 p.398). The possibility that these early episodes of maternal depression, and the associated difficulties in the mother-infant relationship, may be linked to longer-term difficulties in infant development has been addressed in a number of studies (Murray et al. 1999). These have shown a range of adverse outcomes in infants between 12 and 21 months, including behaviour problems (Murray, 1992), cognitive impairments (Lyons-Ruth et al. 1986; Murray, 1992) particularly in boys (Murray, Fiori-Cowley, et al., 1996), interaction difficulties (Stein et al., 1991), and insecurity of attachment (Lyons-Ruth et al., 1986; Teti et al. 1995; Murray, 1992; Hipwell et al. 1999).

More recently, Bernard-Bonnin (2004) asserts that the consequences on the child of maternal postnatal depression are not restricted to infancy, but can extend into toddlerhood, preschool age and even school age (p.575). She tables the consequences of maternal depression within the stages of prenatal through to adolescent, as overleaf (p.576):

**TABLE 1: Consequences of maternal depression
(Bernard-Bonin 2004, p.576)**

Prenatal	Inadequate prenatal care, poor nutrition, higher preterm birth, low birth weight, pre-eclampsia and spontaneous abortion
Infant	Behavioural: anger and protective style of coping, passivity, withdrawal, self-regulatory behaviour, and dysregulated attention and arousal Cognitive: lower cognitive performance
Toddler	Behavioural: passive noncompliance, less mature expression of autonomy, internalizing and externalizing problems, and lower interaction Cognitive: less creative play and lower cognitive performance
School age	Behavioural: impaired adaptive functioning, internalizing and externalizing problems, affective disorders, anxiety disorders and conduct disorders Academic: attention deficit/hyperactivity disorder and lower IQ scores
Adolescent	Behavioural: affective disorders (depression), anxiety disorders, phobias, panic disorders, conduct disorders, substance abuse and alcohol dependence Academic: attention deficit/hyperactivity disorder and learning disorders

Murray's study (1999) also suggests that depression in the early postnatal months and associated issues in the mother-infant relationship can pose a risk to the longer-term behavioural and social development of the child and that these findings present a strong case for early detection and intervention (p.1269). They also present a strong case for supporting parents to stay well, in the first instance.

1.3.2 *Manifold benefits of staying mentally well*

“The focus of (mental) health promotion is to strengthen and enhance the capacity for (mental) health that already exists”.

(Pollett 2007, p.1 – parentheses mine)

Given the considerable burden of emotional suffering and economic losses of PND, many governments, researchers, and clinicians have engaged considerable resources to investigate ways of preventing this illness and to support treatment and recovery.

I discuss a number of prevention studies in *Chapter Two – Literature Review*.

However, of great import is the notion that these primarily risk-focused research findings can provide little guidance about what families can do to optimise positive outcomes (Barnes & Rowe 2010). Often the sections on perinatal mental health promotion and prevention (the two areas frequently grouped together) in international and national mental health reports place emphasis on prevention, early detection, screening, referral to supports and treatment. This is understandable with the current targeting of diseases (National Preventative Health Taskforce 2009 p.7). What is of significance is that little attention is given to promotion. The discussion regarding strengthening and enhancing the capacity for health that already exists (Pollett 2007), of staying mentally well, is poorly addressed.

Positive mental health is a state of well-being, of emotional and spiritual resilience in which the individual is able to realise his or her own abilities, can cope with the normal stresses of life, can work productively, and is able to make a contribution to his or her community (HEA 1997; VicHealth 1999; WHO 2001). Jenkins et al. (2001) describe mental health as “a positive sense of wellbeing, a belief in our own worth, the ability to think, perceive and interpret, to manage life, to communicate, initiate, develop and sustain mutually satisfying relationships (p.8). Ways of promoting mental health include enhancing existing parental capacity, supporting parents to realise their aspirations, to help to satisfy their needs, to support their autonomy, their health literacy, and their adaptation to and coping with the constantly changing environment around them when raising a child. Furthermore, a state of wellbeing allows parents to have control over their health (WHO CPHA 1986).

The WHO draft comprehensive mental health action plan 2013–2020 (WHO 2013) maintains that national efforts to develop and implement health policies and programmes by utilising Primary Health Care, could meet not only the needs of persons with defined mental disorders, but also protect and promote the mental well-being of all citizens (p.1184). Corey Keyes, a prominent researcher in the field of ‘flourishing’ and ‘subjective wellbeing’, and whose research I discuss in *Chapter Two, Literature Review* states that it will be significant when mental health and human development (i.e. viewed positively) are as central to policy decisions as the reduction of disease and illness (2005a, p.8). Furthermore, it will be even more noteworthy when mental health promotion policies are enacted as opposed to being used as political rhetoric (Eva-Llopis, 2005).

1.3.3 Strengths-based approaches to family nursing

The benefits of enhancing the strengths, competencies and resources of individuals and communities, and thereby promoting positive emotional and mental well-being, are well documented in literature (Lahtinen et al. 2005; Barry 2007). The family environment affects its individuals in multiple ways and these impacts may be positive or negative. These effects are determined by the family’s values, beliefs, and ability to manage change (Sittner, Hudson & DeFrain 2007). There is a growing trend globally and in Australia to understand families from a ‘family strengths framework’ (Smith & Ford 2013 p.98) and in doing this, nurses focus on what families are already doing well. They then capitalise on this information by reflecting back to parents how they are already succeeding in their parenting and how they can build upon their established strengths.

Therefore, this strengths-based framework begins from the standpoint that all parents have strengths that can be broadened and developed over time, thus promoting and building resilience in the family (DeFrain & Asay 2007). This framework is an effective method of supporting mental health promotion by enhancing the capacities of parents that already exist. Moreover, this framework also explains why mental health promotion has significance in early parenting; because it supports parents to stay well (Moore, Whitney & Kinukawa 2009; Olson, DeFrain & Skogrand 2010; Smith 2011).

1.3.4 *Neurodevelopment in infancy*

Parenting is strongly linked to current research on neurodevelopment as the infant is born into the world genetically programmed to connect with parents who will become attachment figures in their child's life (Cassidy & Shaver, 1999). Although the attachment system is "hard-wired" in the brain, the experiences that an infant has will directly shape the organization of that system (Siegel 1999). In infancy, the brain is creating neural pathways that help to ensure lifelong health, and so it is imperative that parents are situated to provide the best possible environment for this growth (CCCF2001; McCain 2011; Mustard 2008). Parenting is recognised as a key determinant in fostering healthy child development (CCCF 2001; Maas 2012). The significance of parental mental wellbeing is crucial as how a child is parented plays a central role in an infant's physical survival, cognitive development, emotional maturation, and social growth (Bornstein 2002; Dusing 2012). This makes the examination of mental health promotion in early parenting of critical importance.

1.3.5 *Summary*

In this section I have presented the significance of mental health promotion to early parenting overall through highlighting its importance. Initially, I presented a snapshot of the burden that PND brings to individuals, families and the wider community. From an extensive base of evidence, it can be argued that depression has a significantly negative impact on parents and their children, on communities, the workforce and the economy. This substantial burden behooves health researchers to seek ways to prevent this illness and nurture wellbeing. The benefits of mental health promotion have also been described in this section in order to portray why it is important that a deficit model be replaced by a strengths model as the preferred approach for midwives and child health nurses to employ in early parenting. Finally, a discussion on neurodevelopment in children described why supporting parents to stay well is crucial.

1.4 Approach

A critical approach, which gives emphasis to the historical, social and political context in which the research takes place, urges the researcher to consider social and organisational practices (Street, 1992). In other words, the researcher asks not only ‘what’ and ‘how’ but ‘why’. This critical approach is congruent with the aim of this study to critically analyse how early parenting mental health promotion is understood and implemented by midwives and child health nurses in early parenting services.

Manias and Street (2000) state that inherent in a critical approach is the understanding that through “communicative practices and reflection, researchers and participants” discern an understanding of the culture (p. 235)

I chose to employ this approach as, based on my previous professional experience, I consider mental health promotion’s ‘voice’ to be subdued within the context of early parenting education and posit that societal, economic and political factors are at play in causing the subjugation of this significant construct. In this study I argue that mental health promotion, as opposed to early detection and prevention, is not one of the ‘privileged areas’, a phenomenon highlighted by Carspecken (1996), in midwifery and child health nursing. Furthermore, I contend that mental health promotion is not allowed a ‘voice’ in perinatal education.

The critical approach also demands a close connection between me, the researcher, and the participant in a mutualistic relationship that aims to give voice to participant experiences and perceptions, and in which my subjectivity is an inherent part of this research (Madison 2012 p.10). As a midwife and child health nurse, a deeply reflexive, researcher process was imperative for this type of mutualistic study with my inherent biases and assumptions needing profound scrutiny. I therefore considered that only a critical approach was going to support this study’s potential to engage with factors that explore mental health promotion’s role within early parenting education and to understanding where mental health promotion lies within midwifery and child health nursing practice.

In this study, two qualitative strategies were undertaken: interviewing and document analysis. The interviewing consisted of one-on-one, face-to-face interviews of 13 midwives and 18 child health nurses over a period of 12 months from throughout the

three regions and three hospitals in the state of Tasmania, Australia. For the document analysis, I collected midwifery and child health nursing protocols, policies, education curricula and parenting resources in order to examine them for mental health promotional content.

1.5 Researcher voice

As I write I am conscious of those who might read my work and this has some influence on how I write and in which voice (Lincoln 1991, p.41). There are many voices available to me, the detached observer being the only one I cannot choose (p.45). It is up to me to decide upon which voice will guide me and may involve purpose and/or the need to be represented as many voices (p.42).

In view of the deeply reflexive nature of the critical ethnographical approach, my person is rarely distanced within this thesis, in purpose, approach, and meaning co-creation. I am a midwife and child health nurse and thus only an emic position is available to me. Given these reasons, first person is the most appropriate voice to allow the reader to understand the motivation, setting and 'activist' stance (Fine 1994) that I unreservedly adopt. However, at times, third person is also used to illustrate participants' words and meanings as they must be able to speak for themselves and have their own voice within this critical ethnographical study.

1.6 Context

This section briefly describes the setting of this study and its participants. It also provides a short background to the two parenting services that the study examines.

1.6.1 Place – Tasmania



This study took place in Tasmania, Australia. Although I am originally from Perth, Western Australia, where the majority of my midwifery and child health clinical experience occurred, I moved to Tasmania in 2006 to begin work in academia within the School of Nursing and Midwifery at the University of Tasmania.

The island state of Tasmania lies off the south-east corner of the Australian mainland. The area of the State, including the offshore islands, is about 0.9 per cent of the total area of Australia. It is separated from the mainland by Bass Strait, which is about 240 kilometres in width (ABS, 2010). In 2010 the population was approximately 507,000 with the majority aged between 25 and 64 years of age. In 2009 the life expectancy of males was around 78 years of age with females at 82 (ABS 2010).

The total number of births has been steadily increasing, consistent with trends in other Australian states, with the total number of births in 2011 being 6230 (Zeki, Hilder & Sullivan 2013). As Tasmania does not have a major city, (the state's capital city of Hobart has a relatively small population of approximately 217 973 (ABS 2014), the state is classified as rural. Thus, 4271 of mothers gave birth in 2011 in inner regional areas, 1,809 in the outer regional, 130 in remote areas and 20 in very remote (Zeki et al. 2013).

1.6.2 Setting

Tasmanian Department of Health and Human Resources (DHHS)



The major population centres in Tasmania are the state capital of Hobart in the South, Launceston in the North, and Burnie and Devonport in the North West. There are 29 Local Government Areas which, for DHHS planning purposes, are categorised into seven Primary Health Coordination Areas and three catchment populations: the South, North and North West (DHHS, 2007, p. 10). Many Tasmanian communities are small, which the DHHS (2007) maintains creates a tension between the desire to deliver comprehensive health services locally and the need to structure services so that they are sustainable (p.10).

Midwifery in Tasmania

The Women and Children's Service (WACS) within the DHHS, serves the community in providing obstetric and gynaecological services for families which include pre-pregnancy counseling, pregnancy, birth and postnatal care, including midwifery-led education. These services take place within the Royal Hobart Hospital in the South, the Launceston General Hospital in the North and also in the North West, at the Mersey Hospital at Latrobe (North West), and at the Burnie Private Hospital, which has a co-sharing arrangement with the DHHS. In 2009, Tasmania recorded 6369 births with 71 per cent of mothers birthing in one of these four public birthing facilities within the state. According to the Australian Health Practitioner

Regulation Agency (AHPRA), there are 671 practising registered nurses who are also registered midwives in Tasmania, and 13 practising midwives (AHPRA, 2012).

Child Health Nursing in Tasmania

The Child Health and Parenting Service (CHAPS), as stated by the DHHS (2012), is a health promotional service for parents (based in the community) that provides child-centred and family-focussed services, delivered through individual or group programs, to enhance the health and wellbeing of all young children in Tasmania. CHAPS is situated within the Children and Youth Services (CYS). The CYS structure operates through similar health areas as WACS and area teams are based in the North, North West, South West and South East of the state. Area directors in each region oversee program managers for Child Protection Services, Youth Justice Services, Family Violence Counselling and Support services, Adoption and Out-of-Home Care, and the Child Health and Parenting Service (DHHS, 2012).

The Tasmanian community based child health service was established over 90 years ago, known then as infant welfare or child welfare services, to teach mothers hygienic parenting and to monitor infant growth and development (Brennan, 1998). Today the universal child health service provides health and development assessments for children, support and health/practical parenting information for families through more than 70 child health service sites around Tasmania (DHHS, 2009). Child health nurses do not hold a specific registration, other than nursing, and so the exact number of child health nurses is unknown in Tasmania.

1.7 Thesis overview

In the preface and introductory chapter I presented personal and professional reflections of the steps that led to my researching mental health promotion in early parenting education. I then briefly highlighted why mental health promotion is crucial for the perinatal period. A brief description of the approach to this study together with my researcher voice was then provided. Finally, the context of the study set the scene, describing the participants and their roles within the DHHS. The remainder of the thesis is as described below:

Chapter Two – Literature Review

In this chapter, the literature relevant to this study is analysed in order to establish a gap, the reason why this study has significance in the fields of midwifery, child health nursing and mental health promotion. I summarise, interpret and critically evaluate the existing literature within the three areas most relevant to informing this study: the burden of PND; the vehicles of early parenting midwifery-led education and child health nursing education and support; and mental health promotion within these two vehicles. In doing so, this chapter establishes 1) the current knowledge of mental health promotion within midwifery and child health nursing, 2) the rationale for the thesis, and 3) the formation of my research question.

Chapter Three – Method

In this chapter, I describe and justify the research design and methodological decisions that supported the study's research question regarding early parenting mental health promotion. I discuss why the qualitative research method of critical ethnography was employed above other methods and then outline the methodological steps I performed to implement the study, including the two strategies of interviewing and documentation analysis.

Chapters Four, Five and Six – Combined findings/discussion chapters

The findings for this study are presented as a series of three arguments in three separate findings/discussion chapters. The first of these chapters, entitled '*Much ado about nothing?*' centres on the complexity of mental health promotion and problematises terminology and how it is used in midwifery and child health nursing. The second of these chapters is entitled '*The elephant in the boa constrictor*' and suggests a default illness framework at play when midwives and child health nurses incorporate mental health promotion into their practice with parents. The third and final combined findings/discussion chapter is entitled '*Complicit?*' and suggests a number of barriers within the midwifery and child health nursing care that thwart parents receiving mental health promotion.

Chapter Seven – Conclusion and recommendations

This final chapter concludes the thesis by summarising the findings and outlining recommendations to the two parenting services of how mental health promotion could be achieved through adaptations to the curricula, in servicing and assessment tools used in both services. This chapter also notes limitations and identifies opportunities for future research.

Chapter 2

Literature Review

2.1 Introduction

In this chapter I investigate the global, national and local literature contextual to this study in order to establish a gap; the reason for this study's significance to the fields of midwifery, child health nursing and mental health promotion. This thesis has developed against a background of prevailing historical, cultural, political and philosophical drivers, including gender, the medicalisation of birth, child welfare, parenting, and neoliberalistic funding for provision of care in midwifery and child health nursing. In this chapter I focus briefly upon some of these drivers where they pertain to the exploration of literature examining mental health promotion in early parenting education and support. A more detailed examination of these drivers occurs within the series of arguments in *Chapters Four, Five, and Six*, which seek to explain the study's findings.

2.2 Search Methodology

The search strategy for this review used a number of databases in psychology, sociology, nursing, midwifery, child health, medicine, education, social sciences, history, politics and health promotion. Specific on-line databases included CINAHL, PUBMED, EBSCO, Scopus, Informit, PsycINFO, Proquest, hpsource.net, the Cochrane Library, WHO Reproductive Health Library, NHMRC, Google and Google Scholar. There was no limit to the publication date due to consideration of historical data and foundational or seminal health promotion literature.

Search terms for this literature review included: antenatal, antenatal care, antenatal classes, antenatal depression, capacity building, childbirth classes, childbirth education, child health, child health nurse, child health nursing, emotional care, health, health literacy, health promotion, history of midwifery, history of child health nursing, mental, mental health, mental health promotion, mental wellbeing, midwife,

midwifery, parenting, parenting classes, perinatal classes, perinatal depression, positive mental health, postnatal care, postnatal depression, preventing postnatal depression, self-efficacy, strengths-based, universal prevention, wellbeing, and wellness.

Peer reviewed journals of focus, due to their recognised impact in the fields of health promotion, mental health promotion, midwifery and child health nursing, included: 'Global Health Promotion', 'Health Promotion International', 'Promotion and Education Journal', 'Psychology', 'Birth', 'Midwifery' 'Women and Birth' 'Journal of Midwifery and Women's Health' 'Australian Midwife' 'MIDIRS' 'International Journal of Childbirth', 'Maternal and Child Health Journal', 'Journal of Perinatal Education' 'International Journal of Childbirth Education' 'Journal of Child Health Care', 'Contemporary Nurse' and 'Journal of Advanced Nursing'.

Various mental health websites were explored for links to research on promotion, as were organisations such as Australia's Beyondblue (National website on Depression issues), Auseinet and international sites such as the Marce Society. A number of national and international government websites and Australian government health boards, including the Department of Health and Human Services (Tasmania), were also examined within the context of the search terms.

Selection inclusion criteria included all published papers of health promotion and early parenting, mental health promotion, universal, and (psychosocial) preventive studies as according to Mrazek and Haggerty (1994). Only studies with English translation were reviewed from the time when child health and midwifery records were kept from Brennan's (2007) review of Child Health Nursing in Tasmania through to 2014. The majority of studies in the review are peer reviewed. However, as there was little published research in some areas of mental health promotion for early parenting, all studies (including those in press), regardless of methodology and rigour, were investigated for consideration of concepts and ideas.

Initially, the World Health Organisation (WHO) and the Australian National Health and Medical Research Council (NHMRC) databases were explored for information on global and national mental health promotion and prevention as were the Australian and state government databases for strategic mental health initiatives.

2.3 Defining terms

Early parenting (as defined in Chapter 1 as conception through to first year after birth) and mental health promotion literature encompasses a wide variety of terminology that remains largely ‘in house’ to health professionals and to those who make decisions regarding health funding. It could also be argued that evolving and changing terminology in these two areas ‘mothering *to* parenting’ and ‘mental health promotion *to* emotional wellbeing’ is representative of changing societal influences. Many terms such as ‘primary health care’ and ‘primary care’ are also used interchangeably, causing what Keleher (2001) and McMurray and Clendon (2013) refer to as confusion in these policies involving these significant constructs. Then there are terms that vary from one English speaking country to another such as ‘postnatal to postpartum’. Given the wide variety of terminology that exists in the four areas within this literature review, it is important to explain the terms that have been used in this study and why.

2.3.1 *Health promotion and mental health promotion*

Definitions of health promotion, like health itself, are subject to social and political influence and are, therefore, likely to vary across organisations and social contexts, making universal definition almost impossible.

(Macdonald & Bunton 2002, p10)

Although I acknowledge Macdonald and Bunton’s position above, I am choosing to utilise WHO definitions for the terms health promotion and mental health promotion. Health promotion is acknowledged as a broad construct that began its journey as a significant area of healthcare in Alma Ata with the Declaration of Primary Health Care in 1978 and then moved to a sense of implementation in 1986 within the adoption of the Ottawa Charter. This Charter was a means of interpreting into practice the 1978 declaration with its philosophy of advocacy, enabling and mediating and five action areas of health promotion. A glossary for health promotion by WHO was prepared in the same year (Nutbeam, 1986). The purpose of the glossary was to facilitate communication between the United Nations and other

agencies and the growing numbers of practitioners and organisations working in the field of health promotion (Smith, Tang, & Nutbeam 2007 p.1).

In choosing to use WHO terminology, I am recognising a central, global repository of information that could be seen as having a 'known bias', or at the very least a shared global understanding. This repository continues to develop, drawing upon the knowledge and methods of diverse disciplines and is informed by new evidence about health needs and their underlying determinants (Smith, et al. 2007, p.1). This repository imbues me with a sense of confidence that my choice of terminology is evolving and receptive to peer review. It also offers me a comparative stance in order to discuss findings regarding these concepts (*see Chapter Four*).

2.3.2 Parenting and parenting education

The second area under examination in this literature review is the field of parenting and parenting education. Australian terminology surrounding parenting and parenting education, including midwifery and child health nursing language, will be utilised due to the context of this study and because of the need to remain congruent with the language of my Tasmanian participants.

2.4 Literature review outline

This chapter reviews three areas most relevant to informing this study: the significance of Postnatal Depression (PND); the vehicles of early parenting midwifery-led education and child health nursing support; and mental health promotion within these two vehicles. In discussing the significance of PND I establish the motivation for this study and by discussing the literature regarding the vehicles of midwifery-led education and child health nursing support, the context. Finally I review the literature regarding this study's research focus; that of mental health promotion in early parenting education in order to reveal if and how this construct has been utilised within midwifery-led education and child health nursing support.

The first section (*2.4 Postnatal Depression*) outlines the motivation and imperative for this study by summarising the issue of burden of postnatal depression. As mentioned in *Chapter One, Introduction*, the drive to decrease the development of this illness was the catalyst for this research. Therefore, it is important to place this illness and its aetiology within this review in order to understand why mental health promotion is crucial for parents. As a midwife and child health nurse, in raising the illness as the catalyst, as opposed to the strengths-based approach or neurodevelopment, I am acknowledging one of the main issues that both health professionals and parents encounter (whether in thinking about the illness or experiencing it) and thus I believe PND to be one of the strongest and most acknowledged drivers of mental health promotion activity in early parenting.

This first section will be followed by a review of the literature (*2.5 Parenting education*) that investigates the two vehicles that provide parenting education in the perinatal timeframe and in doing so will provide a context for the role of mental health promotion. The final section to this review (*2.6 Mental health promotion in parenting education*) examines the construct of mental health promotion within midwifery and child health nursing parenting education.

2.5 Postnatal Depression

Description and prevalence

PND, a non-psychotic depressive illness, is a major public health problem (Lumley et al. 2004). The first postnatal year is recognised as a critical period because of the possible long-term consequences of postnatal depression for the women, their partners, the infant and other children (Cox 1989; Murray 1992; Holden 1996). One in five Australian mothers of children aged 24 months or less are diagnosed with depression with more than half of these cases being reported within the perinatal period of before birth to the end of the first year post birth (AIHW 2012). Globally, the average prevalence rate of this postnatal mood disorder has been assessed as around 13-14 per cent (O'Hara & Swain, 1996; Halbreich & Karkun 2005). This percentage has not varied within the last 20 years. However, MacLennan et al. (1996) report that only 49 per cent of mothers who feel seriously depressed seek

help, implying that the number was then and still could be presently, significantly underestimated. In Tasmania, the context for this study, 9.1 per cent of mothers have been diagnosed with perinatal depression (AIHW 2012).

Seminal literature that reports on PND's description, classification and prevalence is situated within the 1990s when this illness came to prominence through the emergence of women's mental health issues as a priority in global health strategic plans. The Australian National Health Medical Research Council's (NHMRC) systematic review on postnatal depression was first published in 1999 and has been reviewed once, in 2008, for currency with few changes adopted, implying that all literature within is still relevant to this illness today.

However, more recently, what has changed is that the illness now has a recognised timeframe of commencing before a baby is born (AIHW 2012) and thus is not restricted in diagnosis to the postnatal period. Antenatal Depression (AND) was recognised in its own right in the early 2000s (NICE, 2007) when its significance in pregnant women was studied through the use in the antenatal period of the Edinburgh Postnatal Depression Scale (Cox, 1989) screening tool. PND and AND have thus become reconfigured and understood by parenting health professionals as *perinatal depression*, meaning that a parent can develop depression in the antenatal period (and which can carry on throughout the first year of birth) rather than its onset being with the postnatal period only.

Postnatal depression (now perinatal depression) has commonly been discussed in terms of risk factors since the seminal work of Mrazek and Haggerty (1994) in illness prevention. These risk factors are understood to increase the likelihood of the development of depression and are biological, psychological, environmental and social in nature. Mrazek and Haggerty (1994) listed these risk factors as including having a parent or close relative with mood disorder, experiencing a severe stressor, having low self-esteem, being female, and living in poverty. More recent risk factors include low social support, poor partner relationship and unwanted pregnancy, a history of prior depression or anxiety, the quality of marital relationship, the age of becoming a parent and the presence of acute and/or chronic stress on maternal mental health (Schmeid et al. 2013). Particular to Australia, the risk factors for perinatal

depression are reported to include living in a rural community, unemployment, and housing and financial difficulties (AIHW 2012).

Although there is a question over whether the opposite of risk is protection (Rowling 2003), the prevention of PND has been identified as decreasing these risk factors and increasing protective factors. A summary of psychosocial and environmental protective factors against postnatal depression include optimism and self-esteem, having a good marital relationship, increased availability of social support, and adequate preparation for the physical and psychosocial changes of parenthood (Fontaine & Jones 1997; Merchant et al. 1995; Cutrona & Troutman 1986; O'Hara 1986; Oakley et al. 1990; Affonso et al. 1991; Wolman et al. 1993). Again, this research is positioned within the 1990s, yet there have been few additions to this list of factors since. In the last 25 years PND preventative studies in early parenting, both universal and selective, have adopted one or a combination of these protective factors in order to mitigate against the development of the illness and have been, for the most part, researched in parenting classes.

2.6 Parenting education classes

One conduit through which parents, globally, may come to understand protective factors is by attending these parenting classes. In Tasmania, these classes are presented to parents by midwives during the perinatal period in the weeks preceding delivery (usually known as antenatal classes or before birth parenting classes) and sometimes in groups postnatally on the ward prior to discharge. Once parents move on from midwifery care, Tasmanian child health nurses then have the role of supporting parents through education (known as anticipatory guidance) and much of this is achieved in parenting classes up to 12 months post birth.

2.6.1 Antenatal or before birth classes

"Everything that happens once a baby is born is the outcome of all that has come before"

(Kitzinger 1992)

Antenatal education is a relatively recent phenomenon, which began in the late 19th and early 20th centuries, and was initially confined to the wealthy (Corkill 1995, p.528) and still is supported by well-educated women in the middle to upper socioeconomic strata (Gagnon & Sandall 2011). In her seminal paper on antenatal education, Nolan (1997) examined the history of antenatal education in the United Kingdom, highlighting why contemporary class attendees represented only a particular section (middle class) of the childbearing population. Nolan believed that the answer to this representation of women began in the late 1800s:

...whilst working class Victorian women suffered the deprivation of urbanization, women from Victorian middle class England were enduring a different kind of social deprivation as they became separated from their women's network (pp.1198-99).

These 'networks of women' were found in families and female friends who had given birth themselves. However, early marriages and living in the country or countries away from mothers and sisters began to separate women away from women; to isolate them from each other and from discussing 'women's business'.

Nolan (1997) describes The Women's League for Health and Beauty (forthwith known as The League) as one of the initial groups which organised classes around the early 1900s to respond to women's needs to gain control over their bodies and to promote their own physical and emotional wellbeing. This development was set against the backdrop of the Suffragette movement and in answer to 'the medical men of the nineteenth century' who became involved in childbirth, persuading women that birth was a pathological condition and that women's knowledge of childbirth was not as specialised as their medical view. These classes proved popular and provided a model for women coming together to discuss matters around their own health.

Although today's antenatal classes owe much to the precedent set by the League, and to the revival of antenatal classes in the 1970s (Nichols et al. 2000), Nolan argues that antenatal education is an artificial construct that can only attempt to replace the factual information and the emotional insights traditionally transmitted through women's networks. Thus, she claims, it has not been a very successful replacement (1997, p.1199). Therefore, it could be argued that antenatal classes developed due to

a number of factors, not least the medicalisation of childbirth and mothers finding themselves seeking formal structures through which to gain knowledge about their own parenting, if and when informal structures no longer existed.

More recent studies regarding antenatal classes emerged in the 1990s as major bodies of research addressing women's health began to increase. A number of authors in the UK, Ireland, Canada, USA, Scandinavia and Australia initiated a focus on the area of midwifery and how women gained autonomy in their own healthcare. In particular, the framework of women-centred care was launched within midwifery education in various forms of implementation on the wards and within the community (Corolan & Hodnett 2007). It was during this timeframe that an examination of how women were engaging with their health care commenced and a spotlight fell on antenatal classes in order to ascertain how they supported mothers.

In Australia during the 1990s, 80 per cent of first time mothers were attending some form of antenatal education (NSW Standing Committee on Social Issues 1998). However, for the most part, large-scale demographic surveys of antenatal class participants were lacking in most countries. Of one of the few surveys, Hancock (1994) found that less than half the women in the United Kingdom who presented for antenatal care attended childbirth preparation classes and that of these women, nearly all were from middle class groups. Other smaller surveys reported similar findings (O'Meara, 1993a; Lumley and Brown, 1993; Redman et al., 1991; Spinelli et al. 2003; Lupton 2000), thus underscoring the middleclass demographics of attendees. Nolan (1997) summarised the qualities of the women from these groups as

...well educated, white women who own cars and are sufficiently articulate to complain if they do not get what they want. They are often professional people with an inbred respect for (and fear of) other professionals (p.1200).

There were few examples of widely adopted standards or guidelines for antenatal education, and a lack of systematic certification or educational grounding for antenatal education teachers (NSW Department of Health 1989). At the time, Gilkison (1991) found that antenatal classes were often designed to prepare women for childbirth in a particular hospital setting and that instead of learning all options available to them, parents only heard about options available or preferred in the

sponsoring hospital. Despite studies during this period acknowledging that antenatal classes were important for parents, O'Meara's (1993a;1993b) sentinel research investigated both Australia's consumers' and providers' responses to childbirth and parenting education, and identified concerns about effectiveness, curriculum content, standards of practice and teacher training for childbirth and parenting education programmes (O'Meara 1993a; O'Meara 1993b). Her study (O'Meara 1993b) noted that classes were not pre-planned in any deliberate fashion and that the educators' teaching practice could be interpreted as being more about 'action' at the time of the classes than adequately predetermined (p.77). Her study (O'Meara 1993b, p.78) also highlighted a Health Department of Victoria (1990) review that found

...a lack of clarity and agreement on principles for childbirth education and inadequate specification of objectives for the programmes being offered; absence of standards of practice and an accreditation process for childbirth educators; inadequacies in the training of health professionals and others currently involved in childbirth education.

(Health Department of Victoria 1990, p.15)

Antenatal literature also highlights that in the middle 1990s, childbirth classes varied greatly in length, and there was a lack of sponsorship, goals, focus and content (Shearer 1996). Furthermore, the educator was acquiring prominence and was seen as having a major role in how and what was included in the classes, with Zwelling (1996) describing each hospital, clinic or private childbirth educator as designing a class as they saw appropriate, often without any consultation with the participants. There were similar issues on non-engagement with parents in the United States and the United Kingdom (Nichols 1995), which could be representative of the view of patients as objects, needing surveillance and monitoring (Henderson 2007). This non-consultative approach was in stark contrast to literature regarding the nurse/patient relationship that was emerging during the 1990s where patients were being described as experts of their own lives, involved in the decision making regarding their care, and the role of health professionals being the provider of information and support (Funnell et al. 1991; Cahill 1992).

The issue of health literacy in antenatal classes was first raised by Renkert and Nutbeam (2001), two of few researchers to investigate participant needs during this

timeframe, when they carried out a series of interviews in Australia, with health care providers, pregnant women and new mothers. The interviews explored how both the content and delivery of antenatal education could be improved to address some of these shortcomings. Findings included disparities between what antenatal educators perceived to be important to parents and what the parents actually desired in antenatal education to support their parenting. A significant example of this was the issue of postnatal parenting information, of which parents wanted more. Antenatal educators believed this to be a minor issue, assuming parents only needed to know about the birth and parents were not ready to receive post birth information (Renkert & Nutbeam 2001, p.387). This raises important questions about who was making the decisions for parents regarding perinatal education and why (Locke & Horton-Salway 2010).

Further studies in the 1990s also found that women who attended antenatal classes judged that the classes did not prepare them for the reality of parenthood, stating that there was a dearth of information regarding postnatal issues such as mental health after birth, basic baby care skills, how to access support (McKay & Yager-Smith 1993; Barclay et al. 1997) and in particular, relationship issues during the perinatal timeframe (Parr 1998). O'Meara's (1993a) research reported a lack of balance between preparations for labour and preparing for parenthood once baby was at home, arguing further that the consequences of this lack of education for parenthood meant that parents did not have the confidence to care for their newborn (p.218).

In contrast to previous studies that omitted to seek parents' opinions regarding content, Peterssen et al. (2004) asked parents what they found helpful in their current classes and for suggestions for the future. This Swedish study's findings indicated that parental education content within this country needed to include knowledge of child development, interplay within the family, contact with other parents, and knowledge of community support. At this time, Peterssen et al. (2004) proposed that parental education ought to focus more on problems in relationships between the parents, stress within the family and interplay between child and parents. This study's findings presaged future ones concerning parents requesting the topics of relationships, parental stress and attachment between child and parent.

Many studies in the 1990s reported positive outcomes from attendance of antenatal classes (Hetherington 1990; Starrock & Johnson 1990; Lederman 1996). However, the evidence from these American case-controlled (Hetherington 1990), retrospective records review (Starrock & Johnson 1990) and interventionist (Lederman 1996) studies mainly pertained to labour and reduced pain medication outcomes. A smaller number of studies including a UK NHS questionnaire for parents in antenatal classes (Spiby et al. 1999), and Nolan's 1997 study into antenatal education recognised reduction in stress and increased satisfaction with labour. However, the majority of studies, including Redman et al's evaluation of an Australian antenatal program (1991) reported little change to birth outcomes in terms of birth or later emotional wellbeing. This literature could be suggestive of emotional wellbeing having little focus within the antenatal content within the classes studied.

2.6.2 *Antenatal (perinatal) classes today*

Current antenatal education programmes are not dissimilar to those in the past and are described in Jaddoe's commentary/review on 'whether antenatal classes work' (2009) as being mainly based on two theoretical models: the natural birth approach, which was introduced by Dick-Read in 1944; and the Lamaze psychoprophylactic method from 1956 (p.863). Some 60 years later, group-based education programmes continue to be utilised as the basis for antenatal parent education and are routine in health care delivery in many parts of the world. Midwives are for the most part the key providers of this education to families with Tasmania being no exception. It is unknown how many midwives deliver these classes at any given time as midwives rotate through a number of positions in antenatal clinics, labour ward to postnatal ward and visits in the home. That the same form of antenatal classes still exists after 60 years could be indicative of either a format that is working very well, or one that is entrenched, and accepted by parents who may feel there is no alternative.

There has been much debate over the past 20 years whether parenting antenatal classes are underutilised by those who 'need them' and over utilised by others who are well educated, middle class and possibly 'do not need them' and whether these classes actually meet the needs of the participants (Cliff & Deery 1997; Nolan 1997; Parr 1998). Certainly, there have been challenges to this line of thinking with

researchers asking if the right outcomes are being measured (Enkin 1990). It has been mooted that well-designed evaluation studies might be the only way to move from common beliefs found within the 1990s' literature to scientific evidence as the basis for these programmes (Jaddoe, 2009). This is further supported by a recent Cochrane review of randomised controlled trials in postnatal education (Bryanton et al. 2013). However, currently the effects of general antenatal education on childbirth or parenthood remain largely unknown as evidenced in a 2011 Cochrane review of this education (Gagnon & Sandall 2011). Given this highlighted gap in evidence, how can their worth be established?

This chapter has reviewed the literature regarding the burden of PND as the study's catalyst. However, it could have as easily reviewed the issue of infant and child neurodevelopment. A most recent review of parenting education (Bryanton et al. 2013) highlighted the issue of brain plasticity as being a significant process that behooves promotion of these classes. If the aim of parenting education is to support parents in making healthy choices for their child, then the laying down of neural pathways or 'blooming' (Santrock 2007) will be determined by a positive environment around the child. Still contested too as the key motivator for these classes, as it was in O'Meara's day, is the issue of midwives today supporting parents to gain confidence in their parenting; described in de Montigny & Lacharite's Canadian study as efficacy in the nurse-parent relationship (2008). These two issues of neurodevelopment and parenting confidence are representative of justification why antenatal classes have worth in perinatal care. Other reasons include parents having the expectation that these classes be offered to them (Nolan 2005). Overall, in a midwifery women-centred philosophical framework (AHPRA 2012), it could be argued for reasons of consumer demand that the classes have their place in midwifery-led care.

Finally, it is significant to note, since the 1990s' research cluster highlighted the fact, that there are still few studies which detail the construction of perinatal education curricula, its content and in particular, which evidence-based practice is used to drive its development (Gagnon & Sandall 2011). Today, as highlighted by Ahldén's (2012) Swedish study, many of the programs used are still typically not based on attendees' needs but on what the educators believe to be important. Midwives' conceptions of

parenting classes and their time spent on providing them have been investigated, and the costs of conducting them have been calculated (Ahldén et al. 2008; Bremberg 2006; SFOC 2008) but not to the extent of exploring in detail any of the concepts taught within the classes and in particular, not regarding what midwives understand about this content. This gap in the literature denotes a significant issue worthy of further investigation.

In summary, literature on midwifery-led education shows that antenatal classes continue to play a role in teaching women to increase their health literacy around labour and feeding practices and to make informed choices about their care today (Locke & Horton-Salway 2010). However, the literature and/or lack of studies also establish that greater engagement with parents in choosing the type of content for the classes is still needed, as is more research that examines the content of these classes, the evidence base underpinning them and the educator him/herself. Having discussed the context of midwifery-led education, I now turn, in the following paragraphs, to reviewing the literature regarding child health nursing and parenting education, or as it is more widely known in child health nursing, anticipatory guidance.

2.6.3 Development of child health nursing and parenting education

Child health nursing is a specialised area of nursing in the community (McMurray & Clendon 2011) and is known by a variety of terms, such as child health nurse, or family and child health nurse. Child Health Nurses (CHNs), as they are known in Tasmania, were originally nurses and midwives who were placed within the community ostensibly to combat a rising mortality rate (Brennan 1998). Their services, established in the early 1920s, were named at the time as infant or child welfare services and within two decades “women cared for their children under the ‘expert’ guidance of nurses...(who) disseminated the idea that mothering skills were learnt rather than instinctive” (Brennan 1998, p. 11). In this way, parallels to the decline in the ‘networks of women’ before and during birth (midwifery care) can be drawn to ‘after birth care’ (child health nursing). These parallels also highlight the way women were no longer perceived to be able to best care for their children and how more formalised structures were pursued.

Child health nursing's link to 'anticipatory guidance' or parenting education commenced when many CHNs were ideologically committed to the 1907 'scientific method' of New Zealand's Dr Truby King. In particular, King's scientific principles for a number of child health areas such as nutrition and sleeping influenced Australian parenting for a number of decades. However, in the beginning, the main area of anticipatory guidance lay in the education of women in 'modern scientific' baby care (Brennan 1998). This 'scientific' education argued that women needed help in understanding how to promote wellness in their children in order to combat infectious diseases. Thus, (Child health) nurses were the ideal choice due to their training which engendered hygiene, cleanliness and ventilation as part of 'scientific hygiene' (Maggs 1996) and efficiency, logic and reason (Reiger 1985).

A scientific approach was therefore adopted during this timeframe with many believing that its methods would solve many health and social issues (Reiger 1985). Scientific mothering was predicated upon child health nursing experts leading the way, with their authority 'needed' to support this discipline style of mothering (Weiner 1994; Brennan 1998). Furthermore, women of the era demanded to have a right to the knowledge that would support their child's health and prevent illness or death (Knapman 1993) and so, much of early education related to breastfeeding and household hygiene (Brennan 1998).

2.6.4 *Child health nursing and anticipatory guidance today*

Ways to better hygiene, illness and accident prevention are still discussed today by CHNs in conversations with parents. However, the scientific model from the past with its link to scientific method and an empirical, quantifying nature of supporting woman and child has broadened out to the adoption of bio and socio-ecological models with their constructions of wider influences on mother and child. Another significant change has included a broadening of terminology from 'mothering' to 'parenting' with the acknowledgment and acceptance of fathering (or significant other) within the microsystem of the child (Bronfenbrenner 2005). Finally, the CHN of today is considered as a resource person, rather than an expert, who provides education and referrals to other community services, such as General Practitioners and Ophthalmologists (Schmied et al. 2008a).

Although the literature alludes to unstructured topics as common within a midwifery-led parenting class, there is a more structured guide to the topics of conversation that the CHNs follow through their workplace assessment forms such as the Family Assessment, Parents' Evaluation of Developmental Status (PEDS), and Edinburgh Postnatal Depression Scale (EPDS). However, there is little research that discusses how this area in child health nursing is carried out. Anticipatory guidance is hard to quantify in evaluation studies due to the fact that much of the interaction between the parent and the child health nurse is hard to capture and the outcomes are only really measurable when the child becomes an adult (Forbes et al. 2007). Usually, this form of education takes place in and around the more formalised structure of weighing babies and can at best be described as latent or covert (Shepherd 2011). It is, therefore, difficult to measure health outcomes from a conversation and studies that have tried are labelled as descriptive only (Forbes et al. 2007) which could imply lacking rigour.

In summary, parenting education plays a major part in the child health nurse's role in supporting parents to anticipate their children's development, during the timeframe of usually from a week or two after the birth and up until around 4 years of age, when 'compulsory' checks fall away. However, the conversations around the different areas of education: milestones in development, weight, height, hearing and sight checks, nutrition, psychosocial assessment and general, biomedical health are difficult to record and little research has been carried out to discover exactly which content, and in what detail, is discussed.

2.6.5 Summary

Midwifery-led parenting education and child health nursing anticipatory guidance are important vehicles for information sharing within early parenting. Yet, there is a limited body of research that discusses the content of these structures in midwifery and even less so in child health nursing. The following section will critique the role of mental health promotion's evolution and then discuss how this significant construct is hitherto explored within parenting education in the perinatal period. In particular, it will explore whether there is a body of research representing an

understanding and examination of mental health promotion within midwifery-led parenting education and child health nursing anticipatory guidance.

2.7 Mental health promotion in parenting education

A fence or an ambulance

*"Twas a dangerous cliff, as they freely confessed,
Though to walk near its crest was so pleasant;
But over its terrible edge there had slipped
A duke and full many a peasant.*

*So the people said something would have to be done,
But their projects did not at all tally;
Some said, 'Put a fence 'round the edge of the cliff,'
Some, 'An ambulance down in the valley.'*

*But the cry for the ambulance carried the day,
For it spread through the neighbouring city;
A fence may be useful or not, it is true,
But each heart became full of pity.*

*For those who slipped over the dangerous cliff;
And the dwellers in highway and alley
Gave pounds and gave pence, not to put up a fence,
But an ambulance down in the valley.*

*'For the cliff is all right, if you're careful,' they said,
'And, if folks even slip and are dropping,
It isn't the slipping that hurts them so much
As the shock down below when they're stopping.'*

*So day after day, as these mishaps occurred,
Quick forth would those rescuers sally
To pick up the victims who fell off the cliff,
With their ambulance down in the valley.*

*Then an old sage remarked: 'It's a marvel to me
That people give far more attention
To repairing results than to stopping the cause,
When they'd much better aim at prevention.*

*Let us stop at its source all this mischief,' cried he,
'Come, neighbours and friends, let us rally;
If the cliff we will fence, we might almost dispense
With the ambulance down in the valley.'*

*'Oh he's a fanatic,' the others rejoined,
'Dispense with the ambulance? Never!
He'd dispense with all charities, too, if he could;
No! No! We'll support them forever.*

*Aren't we picking up folks just as fast as they fall?
And shall this man dictate to us? Shall he?
Why should people of sense stop to put up a fence,
While the ambulance works in the valley?'

But the sensible few, who are practical too,
Will not bear with such nonsense much longer;
They believe that prevention is better than cure,
And their party will soon be the stronger.

Encourage them then, with your purse, voice, and pen,
And while other philanthropists dally,
They will scorn all pretence, and put up a stout fence
On the cliff that hangs over the valley.

Better guide well the young than reclaim them when old,
For the voice of true wisdom is calling.
'To rescue the fallen is good, but 'tis best
To prevent other people from falling.'

Better close up the source of temptation and crime
Than deliver from dungeon or galley;
Better put a strong fence 'round the top of the cliff
Than an ambulance down in the valley".*

(Joseph Malins 1895)

2.7.1 Health Promotion

Health professionals will understand the sentiment behind Malin's century-old poem regarding health promotion. Indeed most will recognise the challenge of the argument regarding 'prevention or cure?' that has stood for over 120 years, and continues to be debated in funding and political circles. However, 'cure' is winning the debate if health funding provision in the health care sector is any indicator, with only one per cent of the total Australian health budget being directed to health promotion and/or prevention (AIHW 2012). It could be argued that there are many ambulances and no doubt many more needed, but not enough fences are being erected in the first place. 'To rescue the fallen is good, but 'tis best/To prevent other people from falling' resonates deeply in health promotion. Can child health nursing and midwifery do more to prevent women and families from falling in the first place? Do we have more 'ambulances' in the guise of illness screening and treatment, rather than fences (prevention) and health promotion? Where and why should health promotion enter into this debate?

Health promotion can be understood through two key historical lenses: the Declaration of Primary Health Care at Alma-Ata (WHO 1978) and ‘its application’ the Ottawa Charter of Health Promotion (WHO, CPHA 1986). Health promotion formally developed largely as a reaction against, and challenge to, the dominant bio-medical, pathogenic model of health, which perceived health as absence of illness (Davies 2013). Today’s proponents of health promotion have in common the basic Ottawa Charter tenets that health promotion aims to empower people to control their own health by obtaining control over the underlying factors influencing their health. However, health promotion is also a political process that seeks healthy structural change in all systems, and involves policy development, political action, community participation and intersectoral collaboration to deal effectively with health issues (Keleher 2001). So, how do parents hope and strive to gain access to this level of control? If health promotion research is underpinned by theories of organizational behaviour, sociology, social psychology, psychology, anthropology, education, economics and political sciences with much of this research limited to health-related behaviour (Eriksson & Lindstrom 2008; Dean 1996), then how does a parent interpret and implement their parenting health goals? Certainly health literacy as a part of health promotion has a significant role in parents being able to achieve this and is discussed in more detail in *Chapter Four*.

Australia has a longstanding claim of promoting health through programs that reflect the principles of the Ottawa Charter (WHO CPHA 1986) and recognising the importance of the social determinants of health (Marmot 1999). Health promotion education programs are delivered by a wide range of organisations, in a wide range of settings and sectors. However, following neoliberalist reforms in the 1990s, government policies have increasingly focused more narrowly on specific diseases and risk factors; moving from Comprehensive Primary Health Care (CPHC) to Selective Primary Health Care (SPHC) (Rifkin & Walt 1986; Cuerto 2004). Chronic disease has become the new banner under which health promotion, social determinants and efforts to address health inequalities fit, echoing Werner’s (1984) predictive sentiments in his article ‘Who killed Primary Health Care?’ on SPHC.

Historically, the Australian approach to policy in the promotion of health has been highly pragmatic. However, a pragmatic and selective, top-down approach has meant

that the process of devising mental health promotion is more about “problem-solving once the issue is on the policy agenda, rather than broad statements of strategic intent or national planning” (Lin & Fawkes 2007, p.205). Jane-Llopis (2006) echoes these issues in her paper on health promotion within four countries, wherein mental health promotion in Europe was described as a priority area, as evidenced in speeches from politicians and reflected in national policy documents. However, when respondents were asked whether mental health promotion was really as much a priority as touted, respondents admitted a far diminished priority than policy documents portrayed.

2.7.2 From health promotion to mental health promotion

Because it could prevent and thereby reduce the incidence of mental illness, mental health promotion is an idea whose time has come.

(Keyes, 2007)

Mental health problems are not exclusive to any special group, and are found in people of all regions, all countries and all societies (WHO 2001) and few would question the rights of individuals in mental illness crises to receive appropriate and targeted support. The percentage of funding to manage this expanding area (mental illness) lies at 7.8 per cent (AIHW 2006) of total health disease expenditure in Australia. However, Malin’s argument to put up fences first and to prevent individuals needing an ambulance in the valley (and thus, all the associated consequences of the mental illness burden on family and community) is today still strongly compelling and yet the amount of preventative funding for mental health promotion in Australia, for example, stands at less than 0.5 per cent of the 7.8 per cent mental health funding available (AIHW 2012). Funding and barriers to economic support are further discussed within Chapter Six, section 6.5.6)

Health promotion continues to be an emerging field of activity, with mental health promotion being one of the most recent areas of focus (WHO 2005a). In its summary report from ‘Promoting Mental Health’, WHO (2005b) argues strongly that mental health promotion must now be forcibly recognised in its policies and legislation; that

the costs of not pursuing mental health promotion is a threat to public health, to quality of life and even to the stability of Europe (p.49). Serious words indeed.

The notion of mental health promotion is not a new one. Jahoda (1958) began a discussion of ‘ideal mental health’ out of the 1947 WHO health declaration that stated “health is not merely the absence of illness but a complete state of physical, psychological and social well-being” (p.1), by separating mental health into three domains. Firstly, she described mental health as involving self-realization in that individuals were allowed to fully exploit their potential. Secondly, mental health included a sense of mastery by the individual over their environment, and, finally, that positive mental health also meant autonomy, as in individuals having the ability to identify, confront, and solve problems (WHO 2005a).

The promotion of mental health is currently situated within the larger construct of health promotion. However, within this construct, mental health promotion sits alongside the prevention and early detection of mental disorders and the treatment and rehabilitation of people with mental illnesses and disabilities (WHO 2005a). In contrast to the more recent and arguably SPHC construct with its targeting of illness prevention, Jahoda (1958) was more interested in an individual’s ability to stay healthy by enhancing his or her self-actualisation (Maslow 1950) or potential (Bronfenbrenner 1996); by his or her ability to gain mastery over (Bandura 1977) or make coherent sense (Antonovsky 1987) of his or her environment. Moreover, Jahoda saw mental health promotion at its best in people who exercised the greatest degree of individual autonomy as also enjoying the best of health (Buchanan 2006). It could be argued that we no longer seem to be supporting people to increase the capacity that already exists (Pollett 2007); we seem to have taken a different road to mental health promotion and not the one less travelled.

2.7.3 *Current mental health promotion in midwifery-led parenting education*

A discussion of all programmes that address the nursing partnership to parent would be too large a field for this study that aims to look specifically at how midwives and child health nurses support the wellbeing of parents in the perinatal period

(conception to the end of the first year post birth). Many nursing/parent programmes, such as the studies of Olds address older children and target programs for socially and economically disadvantaged women (1994, 1995, 2006, 2007). In contrast, this study has a universal focus. Importantly, parenting /nurse research such as Solchany's work (2001) that reviews mental illness prevention in parenting is an essential reference were this study reviewing mental illness prevention. However, the focus of this study is mental health promotion and staying well in the first place.

The importance of the transition to parenthood, including a mother's view of parenting, her parenting skills, her self-esteem and her relationship with her partner are well documented and have been recognised as high as policy level in the United Kingdom (NICE NHS 2010). In spite of this, literature suggests that antenatal education continues to focus either on labour and birth and fails to address parents' needs in relation to the reality of new parenthood. More emotional and informational support for parents both antenatally and postnatally has been a recommendation of several studies (Lothian 2008; Jaddoe 2009).

In families, transitions represent periods of change where there are shifts in lifestyles from one stage to another. Research has consistently demonstrated that having a baby is often a stressful event and brings about more profound changes than any other developmental stage of the family life-cycle (NHMRC 2008). Women report significant changes to their lifestyles and routines, easy adaptation is not a usual occurrence, and is commonly problematic (Lothian 2008). Many parents-to-be are stressed by the strain of working life and societal expectations, which may interfere with their everyday life during pregnancy. According to national recommendations, the psychosocial part of the parenthood should be in focus, but does not at present appear to be a priority (Young 2008; NHMRC 2008).

In particular, there is little evidence to show how mental health (as opposed to an explanation of postnatal depression (PND) and its signs and symptoms) is promoted in a broad sense in midwifery-led education. However, there have been a small number of universal and selective studies over the past 20 years that have targeted antenatal classes with single entity interventions to decrease formation of PND. For example, researchers have used antenatal classes to see if protective factors included

in activities or through information sharing (education) would have positive outcomes. Examples have included postpartum psychosocial adjustment of women and men (Matthey et al. 2004), preparing for the early weeks of parenting (Mercer 2006; Schmied et al. 2008a; Milgrom et al. 2010), and raising self-efficacy (de Montigny & Lacharite 2008) in the parents. Furthermore, information to attendees regarding parent and baby attachment has appeared in antenatal classes more recently. Overall, a Cochrane review by Dennis & Creedy (2004) found that whether these interventions have had significant success in decreasing the development of PND is still unknown, although parental satisfaction has been seen an important outcome in itself. The majority of these types of studies argue that more wide scale and multiple aspect studies be performed before a definitive consensus about effectiveness can be formed (Gagnon & Sandall 2011).

In essence, there has been some research regarding protective factors and thus prevention from developing PND or decreasing stress and anxiety in the perinatal period. However, a systematic review of prevention studies found that there still appears to be inadequate “articulation of mechanisms” (Boath 2005) to tie these single entities together to form a specific framework in perinatal education that supports parents to exploit their potential and their existing strengths as parents (p.191). It could be argued that there still needs to be midwifery-led education that encourages mastery over or making sense of the parents’ living, working, support environment and/or; how parents achieve a sense of autonomy in the perinatal period by self-identifying and confronting and then being supported to solve any issues (Jahoda 1958; WHO 2004).

This lack of promotion of the existing parenting capacity is not uncommon as evidenced in a Canadian literature review that examined mental health promotion (Pollett 2007). A US study examining prenatal guidelines found a “predominant focus on the physical verses psychological needs; an increasing attentiveness to risk as opposed to protective factors and a lack of broad health promotion focus” (Hanson, 2009, p.460). Numerous studies highlight that midwives acknowledge that a risk orientation detracts from the reality that most women have healthy pregnancies and that overemphasising these potential risks can jeopardise opportunities to promote the long-term health of the woman and her family, especially given the

limited time constraints and organisational structures and requirements facing current midwifery care (Reiger & Lane 2012; McLachlan et al. 2006; Morrow et al. 2011). This argument is further expanded upon in *Chapter Seven*.

In summary, research into mental health promotion in midwifery-led education has been represented in single factor preventative studies which report that their effectiveness is unknown. Education also lies in information sharing about PND and its symptoms. However, there have been few studies that explore the actual status of mental health promotion content in midwifery-led education and how midwives who develop and deliver this content understand mental health promotion.

2.7.4 *Current mental health promotion in child health nursing-led parenting education*

The history of child health nursing incorporating mental health promotion can be traced back to the 1930s, when psychology as a discipline gained prominence and informed the thinking of health reformers who assumed “that a child brought up from infancy to be regular and punctual in all things would later be likely to be a responsible, orderly citizen and member of the workforce” (Brennan 2007). However, apart from the academic influence of psychology in the 1930s, there is little to suggest that up until recent times, mental health promotion dialogue has played a large part in this field. Child health nursing now recognises bio and socio-ecological models of human development frameworks as vital in underpinning their models of care, and accordingly, there has been a shift towards enhancing the provision of psychological support for parents and families (Barnes et al. 2003; Briggs 2007). Recent policy directions in most states of Australia now require CHNs to include a standardised mental health approach to the assessment of the parent (in most instances the mother), including screening for perinatal depression, substance misuse, and domestic violence (Schmied et al. 2008a; NSW Health 2005a).

In summary, there is little research into child health nursing-led education or anticipatory guidance, let alone mental health promotion within the field. There is limited research that discusses the implementation of perinatal depression screening within CHNs’ practice (Wickberg 2000; Schmied et al. 2013), and emotional care

(Shepherd 2011). Specifically, there are few studies that explore CHNs' understanding of mental health promotion and how they implement this construct in their practice.

2.8 Conclusion

It could be argued that the dominant message from health promotion literature is one of targeting illness through preventive studies and prevention and early detection screening tools as opposed to promoting the existing capacity in parents.

Furthermore, mental health promotion appears to target decreasing perinatal depression development yet sheds little light on promoting ways to support parents remaining mentally or emotionally well in the first instance. Moreover, there are few studies that aim to explore where the mental health promotional content is located within midwifery-led perinatal classes and child health nursing anticipatory guidance. Finally, there is little research that examines how mental health promotion, as opposed to screening for mental illness, is understood and delivered by midwives and child health nurses.

Chapter 3

Methodology

3.1 Introduction

The purpose of this chapter is to describe and justify the research design and methodological decisions that were made in this study. The chapter is divided into three parts: 'methodology', 'coordinating the data' and 'analysing the data'.

'Methodology' describes the development of the research question that evolved from my literature review and explains how my ontological and epistemological positioning influenced a critical ethnographical approach to this study. This first part also describes the two methodological strategies and processes of interviewing and document analysis that were used to complete the data collection. 'Coordinating the data' outlines how the data were collected and 'Analysing the data' describes how the data were analysed. This chapter also includes an account, entitled 'Reflexivity', of how I believe my assumptions informed my interpretation of the data. Overall, the chapter describes the process of how this study was achieved.

3.2 Methodology

This section specifically describes the development of the methodology for the study and, in doing so, outlines my decisions about which paradigm within which to situate this study, the steps that led to my research question and my deliberations about which approach and methodological strategies would best answer this research question. This first part also describes the interviewing process.

Analysis of the literature led me to the conclusion that midwifery-led parenting education and child health nursing anticipatory guidance were important vehicles for information-sharing within early parenting. However, it is evident that there was a limited body of research that discussed the content of these structures in midwifery and even less so in child health nursing. Review of the literature also highlighted how mental health promotion that targets decreasing PND development sheds little

light on promoting ways to support parents remaining mentally or emotionally well in the first instance. Importantly, the literature review revealed that mental health promotional content located within midwifery-led perinatal classes and child health nursing anticipatory guidance was not well documented. Overall, review of existing literature confirmed that there was an absence of research that examined how mental health promotion, as opposed to screening for mental illness, was understood and delivered by midwives and child health nurses.

In order to study this gap in the literature I began by considering which research question(s) could meet my research aim of exploring mental health promotion in midwifery and child health nursing-led perinatal education. I started with *“how do midwives and child health nurses think mental health promotion can be taught?”* and *“how do midwives and child health nurses construct the mental health promotional content for the classes?”* However, when reflecting upon these research questions, I realised I needed to take a step back to question my assumptions that, in fact, there would be answers to these questions. I reflected I could be making an assumption that there were curricula and that mental health promotion was taking place.

Furthermore, from the literature review’s findings, it seemed more appropriate that the research question examine the actual construct of mental health promotion overall and how it was understood; in other words, how these health professionals intrinsically and socially understood this construct. I say ‘appropriate’ as the literature review painted a confused picture of what constituted mental health, mental illness, mental health prevention and mental health promotion. Thus, I determined it was even more important to begin by exploring midwives’ and child health nurses’ understanding of mental health promotion in early parenting preparation in order to establish whether their understandings supported or refuted this confusion of terminology. Foundational questions such as *“what is mental health promotion?”* and *“what do midwives and child health nurses understand by the concept of mental health promotion?”* emerged in my considerations. Furthermore, I realised that midwives’ and child health nurses’ understandings of mental health promotion would encompass a wider range of parenting education than perinatal parenting classes/anticipatory guidance; that I would need to consider the entirety of their practices in order to undertake a comprehensive exploration of this construct.

3.2.1 *Positioning this study within a research paradigm*

My earlier positioning of wanting midwives and child health nurses to tell me what mental health promotional content there was in their curricula, had changed to wanting to explore what they thought mental health promotion meant to them; to know how and where their knowledge came from: their ideas, thoughts, associations, and meanings. This movement from content analysis to wanting to include a deeper positioning on understanding meaning revealed to me that I had a worldview that I needed to explore further before I could decide on a final research question.

So, what was my world view? How did I position myself ontologically and epistemologically? As I explored these two questions, I found, ontologically, that my assumptions included multiple realities or truths of peoples' experiences, together with how everyone had his or her own story or journey to tell (Denzin & Lincoln 1994, p.109). Epistemologically, I believed people made sense of many social realities due to their varying human experiences; that all human behaviour belongs within a context and can vary accordingly (Denzin & Lincoln 1994, p.111). However, I also believed these multiple realities could be 'taken for granted' realities (Schultz 1972 p.74) which needed additional analysis. I further believed that the culture in which we live can "entrap us in realities that often reflect hidden meanings and unrecognised consequences" (Thomas 1993 p.3). Moreover, my world view of injustice had been influenced by my midwifery and child health nursing experiences of policies and protocols which were diminished through institutional power plays and which ultimately did not serve the interests of parents.

Immersing myself in the methodological literature, I considered initially that my study was compatible with the constructivist paradigm as I was planning to explore how midwives and child health nurses understood mental health promotion and how it was constructed by them for practice. However, I soon realised my study required more than a rigorous examination of ideas and discourse from within participants' construction of mental health promotion; there was also the need to consider how much institutional power plays regarding mental health promotion in early parenting constituted political challenge (Thomas & Maolchatha 1983 p.146).

The paramount issue was not only understanding the child health nurses' and midwives' construction of mental health promotion, but also examining thoroughly the 'why' of their knowledge and practice of mental health promotion. Thus, the study would be congruent within a constructivist paradigm (Guba and Lincoln, 2005 p. 190) but only in some aspects; construction would tell 'what' and 'how'. The main focus of the study needed to emphasise 'why' and so a qualitative study positioned within the critical paradigm would best support my research aim.

3.2.2 Research question

In order to ensure a linear approach throughout the thesis that would acknowledge qualitative exploration and critical intent, my research question was ultimately constructed from a health discourse related to Antonovsky's Salutogenic Model (1979) from the late 1970s. This discourse reflected Antonovsky's ideas and the explanations for what health was at that time and the social, economic and political contexts that determined it (Robertson 1998 p.155). The research question replicated one of Antonovsky's (1979) where he asked "what creates health?" This was in turn reiterated by Kickbush (1996) in her tribute to Antonovsky in which she stated that this question should always be the leading question of health promotion (p.5). My research question "*what do midwives and child health nurses consider "creates mental health" in the perinatal period?"*" aimed to encapsulate the same considerations of questioning 'what creates mental health?' as opposed to what causes mental illness. It also aimed to ascertain whether mental health promotion was incorporated in midwifery and child health settings (Kickbush 1996 p.5) or as she stated "where is health created?"

Furthermore, "*What creates mental health?"*" was in keeping with Antonovsky's Salutogenic model (1979) that asked the question "how is health created?" (salutogenic) rather than "why did health break down?" (pathogenic). Antonovsky (1987) reasoned that the pathogenic approach pressures us to focus on the disease or illness and in doing so can blind us to subjective interpretation of the person who is ill. He also asserted that thinking in pathogenic terms was most comfortable with the 'magic-bullet' approach (one disease, one cure) and could lead to resistance of many to the concept of multiple causations (p.37). This present study's research question

thus aligned with the literature review's conclusions in that it raised the possibility of allowing participants to engage with 'multiple causations' and to consider all that supports the capacity in parents that already exists (Pollett 2007, p.1). It also aligned with a strengths-based approach in keeping with strengths-based language (Smith & Ford 2013). Significantly, this question challenged risk factor identification and targeted, illness approaches and thus could highlight if these risk approaches were being used by midwives and child health nurses, as opposed to those with a wellness orientation.

3.2.3 Ethnographical approach

The most suitable approach to answer my research question was one that supported examining how midwives and child health nurses constructed their practice of mental health promotion by firstly exploring their understanding of the construct. Secondly, the approach also needed to support reviewing more than one source of data in order to gain as complete a picture as possible of mental health promotion in early parenting in Tasmania. After reviewing the different qualitative approaches, I decided that the traditions of phenomenology and ethnography could be drawn upon to fulfil the first criterion. However, as phenomenological research focuses more on an individual's perspective, or of individuals who *experience* a common phenomenon (Polkinghorne 1989, p.43), an ethnographical approach was better suited to my research question as it focuses on individuals, such as midwives or child health nurses with a shared pattern of beliefs (Osborne 1998). Ethnography also requires a more analytical examination of shared beliefs, practices, artefacts, and behaviours (Goetz and LeCompte, 1984, pp.2-3) and advocates the use of more than one data source.

Ethnography has at its core a need to understand the participant's reality through interviews and other sources of a qualitative nature (Grbich 1999, p.158), and to obtain the understandings and meanings constructed by the participants as they undertake their daily activities (p.159). As such, it was clear that ethnography was most appropriate to meet my research aim as it also had the distinction of 'a priori flavour' (Osborne 1998, p.178): the investigation started with a problem or topic (*"what creates mental health promotion in early parenting?"*) as well as an

associated theory or model (mental health promotion construct). My research question needed to determine my choice of method and not the other way around (Mills 1959) and so once I had decided that an ethnographical approach would best answer my research question, and given my critical stance, it was obvious which of the three types of ethnography: classical, critical and postmodern/post structural (Grbich 1999) I would be utilising in my study.

3.2.4 Critical ethnography

Derived from the Greek Krites ("judge"), the Latin term criticus implies an evaluative judgment of meaning and method in research, policy, and human activity. A critical act begins with the recognition that ideas possess the capacity both to control and to liberate.

(Thomas 1983, p.148)

Malinowski (1967) advises that it is preferable to enter the research field with 'foreshadowed problems' rather than preconceived ideas that limit one's view. Given that my 'foreshadowed problems' consisted of an awareness, as discussed in the literature review (*Chapter Two*), of key issues and debates (Grbich 1999) surrounding mental health and mental health promotion, my approach needed to be one that encapsulated these social, economic and political elements. My research aim to critically analyse how early parenting mental health promotion is understood and implemented by midwives and child health nurses in early parenting services, assumed an outcome of investing in and transforming the area of mental health promotion within early parenting in Tasmania. My research question of "*what creates mental health promotion?*" was also, in itself, an ideological question in which social, political and power issues were at play (Antonovsky 1979). Thus, there was an evolving alignment with proponents of a 'critical' ethnography: Thomas (1993) and his writings on praxis-oriented ethnographic traditions with a goal of political action; Madison (2012) with her critical ethnographical writings on performance; Giroux (1983;2014) whose works examine the construction of identity within educational contexts throughout the broader determinants of neoliberalism; and McLaren (1995;2010) whose critical ethnographical work is mainly situated in

critical pedagogy; and Street's (1992) seminal work in nursing power relations. All were fundamental to my understanding of this critical ethnographic approach.

In aligning my study with a critical ethnographic approach, I would be pursuing ethnography with a more direct style of thinking than classic ethnography (Madison 2012). Significantly, critical ethnography examines the relationships between knowledge, society, and political action (Thomas 1993). Health *is* political with policy makers seeking to maximise political support (Goddard et al. 2006, p.82). Therefore, critical ethnography could offer the appropriate methodological means by which to study a 'political' goal of supporting mental health promotion within the child health and maternity services in Tasmania.

Critical ethnography emerged from the 'Chicago 'School', as opposed to Critical Social Theory which emanated from the Frankfurt School of Germany and had at its core an interest in liberating persons from domination and constraining conditions (Steven 1989, p.58). Chicago sociology referred to a particular worldview and fieldwork research method preferred by many of the Chicago analysts in the 1920s and 1930s, aligning with, amongst others, Mead philosophically and Sapir anthropologically (Thomas 1983). This critical component or critical thought originated in a long tradition of intellectual rebellion in which rigorous examination of ideas and discourse constituted political challenge (Thomas 1983, p.146) and thus research becomes critical when theoretical and methodological approaches, such as ethnography, are re-examined for their critical component (p. 392).

A critical ethnographical approach to this study meant that mental health promotion might gain a greater voice, be less marginalised (Foley 2010), and in doing so would allow some form of 'liberation' to parents in their parenting experience. In choosing critical ethnography as my research methodology I was seeking to support action *amongst* midwives and child health nurses in early parenting and at the same time "provide rigorous and convincing evidence to those in decision-making positions" (Cook 2005, p. 131). Overall, I wanted to ensure that mental health promotion by midwives and child health nurses would serve parental interests in mental wellbeing.

How do mental health promotion and critical ethnography intersect? Contemporary perspectives see health as a socio-political phenomenon influenced by issues of

power and dominance (Cook 2005). If health promotion is concerned with empowering individuals – and in this case I refer to empowerment as self-actualisation or autonomy as discussed in *Chapter Two* and not an understanding of empowerment as compliance (Nyatanga & Dann 2002) – then it could be argued that both health promotion and critical ethnography aim to give more power, and thus control, to parents affected by funding allocation and health policies (Cook 2005). This would be so if knowledge were the vehicle through which parents were able to exert more control over the circumstances within the perinatal period (Thomas 1993).

Of note is that critical ethnography emerges when a member of a culture becomes reflective and asks not only “what is this?” but also “what could this be?” (Thomas (1993, p.v). To this end, as a midwife and child health nurse, and as a member of the perinatal parenting culture, I saw this approach as supporting my ability to provoke reflection and facilitate change (De Laine 1997, p.127) in programs and services regarding early parenting mental health promotion. Furthermore, this critical approach would have the potential of “forcing players” who decide about maternity services “to act upon value commitments in the midst of political agendas” (Thomas 1993, p.ii) as commitments to invest in the early childhood years and in mental health services are politically determined.

3.3 Method

This section describes the strategies used to collect data for this study. The two main collection strategies were interviewing and document analysis. It is significant to note that I did not engage in participant observation as a major strategy for data collection, although this strategy is usually undertaken in ethnography. A disadvantage to participant observation can include those being observed changing how they practise (Grbich 1999). I chose not to pursue this methodology as I considered my presence as an academic from the University of Tasmania in midwifery and child health as too intrusive; that my ‘habitas’ of midwifery and child health academic capital, as Bourdieu (1991) defines it, would be too great an influence on any participants and thus on any data I would collect in this way.

I also considered that I would gather richer and more detailed data, a greater bricolage (Kinchloe, McLaren and Steinberg 2011), through mutualistic, co-constructed interviews. Through that approach it seemed likely that any perceived ‘outsider academic’ power would be diminished through my ‘interested’ – as opposed to ‘disinterested’ (Merton 1973) – motivation. Through the methodology of interviewing, my roles of midwife and child health nurse engendered a mutual ‘discourse’, as described by Foucault (1993), with mutual power between me and the participants. In this way more rapport and disclosure occurred and my presence as academic researcher was seemingly less in the foreground and thus less intrusive.

As a way of structuring my two methodological strategies, the interviewing process was based on Fontana and Frey’s (2008) framework and the process of document analysis on Bowen’s (2009) procedures.

3.3.1 *Interviewing*

I chose to use interviewing in my study as the first of two data collection strategies to answer my research question. Firstly, this was reflective of a desire to understand Tasmanian midwives’ and child health nurses’ constructions of knowledge and practice of mental health promotion. Secondly, interviewing was chosen as it would be purposeful and employ open-ended questions to explore participant reality, perceptions and constructions of mental health promotion. These explorations could then be documented, understood, and finally interpreted (Goetz & LeCompte 1984). Importantly, as interviewing “provides a way of generating data about a ‘social world’ by asking people to talk about their lives” (Holstein & Gubrium 2003 p.3), it was a data collection strategy that would be appropriate for answering my research question.

Interviewing is a complex act, intimately connected to context. Fontana & Frey highlight this when they state that interviewing is “inextricably and unavoidably historically, politically and contextually bound” (2010, p. 695). Congruent with my critical ethnographic approach was the significance of interviews as a data collection strategy as they can be structured to draw out the nature of these ‘bound’ influences. The roles of midwife and child health nurse include interviewing parents on a daily

basis and so, with “interviewing being a routine, technical practice and pervasive taken-for-granted activity in our culture, and thus, acceptable to participants as a legitimate means of data collection” (Mischler 1986, p.23).

Furthermore, Kvale’s (1996) proposition that the interview is a site for the construction of knowledge is in agreement with Fontana and Frey (2008) who, in their discussion of elements (p.696) state that the context of the researcher and participant is central to the process of data collection. Thus, exploring and identifying context as part of the setting up of the interviews became central to data collection and interpretation (Fontana & Frey 2008, p.697). Fontana and Frey also maintain that an interview is not a neutral tool of data gathering but rather an active interaction between two people leading to negotiated, contextually based results (p.697). Furthermore, they argue that it is one of the most common and powerful ways in which to explore my fellow midwives and child health nurses’ understanding of such a significant construct as mental health promotion.

3.3.2 Interview process

Fontana and Frey (2008) discuss the beginning of the interview process as firstly assessing the setting or as they put simply ‘*how do I get in?*’ This part of the interviewing process required time and extensive planning, as I believed it to be one of the most crucial elements to my study. A thorough grasp of common language would clearly support tactics and strategies to highlight the importance of what Kalekin-Fishman (2002) describes as “the need to elicit authentic self-expression of the interviewee”, ideally resulting in what she further explains as “uninhibited interaction” (p.3). As a midwife and child health nurse, I was confident that I would be able to “understand the language and culture of the respondents” (Fontana & Frey 2008, p.706) and thus be accepted within the two services. However, I considered it was a disadvantage that I had not worked in the midwifery and child health services in Tasmania, as my clinical work in these fields occurred in the state of Western Australia, hence I did not know the services intimately and the personnel involved. Firstly, I spoke to Tasmanian academic colleagues in these two areas who had contacts and decided upon the key people I would approach firstly via phone for a quick introduction of myself and my proposed study. I also included a direction that

I would be in contact with a follow-up email with more detailed information afterwards. In this follow up email I discussed my background and proposed PhD study and requested a face-to-face appointment in which I would be hoping to secure in-principle support for my study's ethics application.

How was I then "to present myself" (Fontana & Frey 2008, p.706)? I began to carefully construct my ideas about the study in order to show the key contacts from Women's and Children's Services (WACS) and Child Health and Parenting Services (CHAPS) how the research could be of benefit to the two services. In doing this, I was mindful of my critical ethnographic stance that aimed to generate an insight (Baumbusch 2011) into the complex fields of midwifery and child health nursing in which this study was situated. I was also aware that the study included an empathic approach that Fontana and Frey describe as "taking an ethical stance in favour of the individual or group being studied" (p.696). In doing so I would be a partner in advocating for changes to mental health policies, if needed. It was with this intention of supporting the services, to either show off the good work already being done and/or to support improving the area of mental health promotion, that I approached Tasmania's co-directors in the three regions' maternity services and the Tasmanian director of child health nursing.

My description of the study's aim, and the advocacy that the study could afford the services, were well received and soon after I received letters of in-principle support from the services (Appendix 1), and was able to use those letters in my submission for ethics' approval. These meetings with key contacts were instrumental in beginning a trust relationship between me, the services, and the study. It was also during these preliminary meetings that I was invited to attend meetings with managers within the three regions (of child health nursing) and three hospitals (midwifery) within Tasmania, as a way of accessing documents and of being introduced to the services and their environment. These visits were invaluable, firstly, in my being supported by managers who directed me to the midwives at the different hospitals who could best supply me with the documents needed for my second data source. Secondly, discussion with management allowed me to observe their practices and how the services were organised.

Many informal discussions, in which I made field notes, also took place during these visits and these field notes were later used to inform the study. Significantly, these informal discussions with management contributed to my acceptance by the different services and again in observing midwifery and child health nursing actions at the ‘coal face’.

Once I had gained in-principle support from the services, and for the purposes of the ethics minimal risk application, I developed a number of broad and focussed questions (the process of which is discussed later in this chapter) that supported answering my research question and guided me in my interviews with the midwives and child health nurses. I knew that in order to be congruent with my qualitative stance, my questions needed to be open-ended questions such as ‘*tell me about...*’ or naturally arising during the interview ‘*you said a moment ago...can you tell me more about...?*’ It was also necessary that these types of questions gave the participant the time and scope to talk about his or her ideas, opinions or constructions of the research topic. I also knew, in order for the interview to be a conversation, or what Brown and Dobran describe as a “dialogical relationship” (2004), that I needed to build rapport. Given that I was a midwife and a child health nurse there was a common culture and language (Grbich 1999) that I shared with the participants and a sense of relationship was easily established. Before the interviews began, I was confident that my interviewing skills were at a high level, as they had been developed and refined over 20 years in my roles of teacher, nurse, midwife, and child health nurse. Furthermore, at the time of the interviews, I had been facilitating undergraduate nursing communication units for over seven years in which a nursing assessment or interview was the highest priority.

As discussed in my literature review (*Chapter Two*), and again in congruence with my critical approach of ‘what, but also why is it so?’, my series of open-ended questions (described later in this chapter) focussed on mental health, mental wellbeing and mental health promotion. In a more focussed manner, the questions asked how this knowledge had been constructed by the participant, how they thought this information was being disseminated to clients, and to consider how clients would define mental health promotion. However, firstly, I needed to work out which

interviewing style would best establish rapport and would best support my participants to discuss with me their constructions of mental health promotion.

I decided upon semi structured interviews for the 'guided interview' (Grbich 1999) as this type of interview style helped to focus me initially in my questioning. Then, as the interview progressed, I was able to interact more and more with the interviewee. In turn, I was more connected with the content of the conversation occurring around mental health promotion. Furthermore, this type of focused yet unstructured interview supported me to comprehend the participants' constructions without any a priori categorisation that a structured interview might normally impose. Therefore, without this imposition, my field of inquiry was unlimited (Fontana & Frey 2008). I was aware that in order to gather as much data as possible, my choice of a semi-guided interview meant that I provided only minimally directive framework, which then enabled both me and the participant to access and identify key areas (Grbich 1999) within the early parenting mental health promotion context.

3.3.3 Interview co-construction and mutualistic relationship

I was confident throughout the interviews that I had chosen a type of questioning that helped me refocus on the topic at hand when the conversation flowed to other issues unrelated to the topic. At the same time this type of questioning allowed the participant to guide the discussion, with my interaction being supportive of this rather than obstructing. I also worked to ensure that my interviewing style was congruent with gaining the information I needed in order to answer my research question whilst being supportive of allowing the participant to talk about his or her construction of mental health promotion. Examples of this interviewing style included allowing the participant to deviate from the question at times in order for them to explore what they were trying to say. However, it also meant that I could gently refocus them on the question by summarising what they were saying and then tying it back to the question.

I was aware, as a midwife and child health nurse, that a large part of the interview process involved construction of the participants' understandings and meanings which included my input – a sense of co-construction that Holstein and Gubrium

describe as ‘unavoidable’ in the process (2003, p.4). For example, the meanings I gained from the interviews were not “merely aptly elicited, nor simply transported” through the midwives’ and child health nurses’ replies; they were “actively and socially assembled in the interview encounter” (Holstein & Gubrium 2003, p.4). It would be fair to say that the more interviews I completed, the more I valued Holstein and Gubrium’s (1995) claim that the “key within the active nature of the interview process is that it leads to a contextually bound and mutually created story” (p.7) In summary, my semi structured interviews guided and refocused conversation using open-ended questions, within an interactional, co-constructive, mutualistic interview style.

3.3.4 Interview recruitment

All DHHS midwives and child health nurses were invited to take part in this study as I wanted to capture the experiences of these health professionals who work in partnership with parents in mental health promotion. As per my ethics application, the mode of recruitment was via emails. I had already organised and attended meetings with WACS and CHAPS directors face-to-face and had sought permission to have my emails of recruitment go through them as the third party. Once ethics’ approval (Appendix 2) was granted by the University of Tasmania and the Human Research Ethics Committee (Tasmania) Network and Department of Health and Human Services (DHHS) – all one process in Tasmania – the directors sent out my email to all staff (all Tasmanian midwives and all Tasmanian child health nurses in the Department of Health and Human Services) in their services with an encouragement to participate in this state-wide study. This email on the directors’ behalves was significant in establishing my credentials (my initial email was also sent to staff for their information) and also showed that the study was being supported by key decision-makers. These highly influential supporters stated via these emails to staff that they would be “looking forward to seeing results from the study” and to seeing “how the results and recommendations could be incorporated within policies and protocols” regarding Tasmanian early parenting mental health promotion. I also attended a Tasmanian midwifery conference and was allocated time to discuss the study as a way of recruitment.

Soon after the emails were disseminated, responses from potential participants came in to my password-protected, work email address and with each participant I established an email chain discussing time and place for an interview that was anticipated to take an hour. At the time of dissemination of my recruitment email by the directors, an information letter and a consent form were also attached for prospective participants' information (Appendix 3). At the time of the interview, I asked participants if they had any questions and reminded them that they could withdraw from the study at any time. The interviews with midwives mostly took place within the hospital in parent interview rooms, and sometimes during their lunch breaks. There were two interviews with midwives that occurred in their homes. All but one of the child health nurse interviews took place at the clinic of the nurse, scheduled in between parent appointments. One child health nurse elected to be interviewed at home on a non-working day.

3.3.5 Documents process

"The qualitative researcher is expected to draw upon multiple (at least two) sources of evidence; that is, to seek convergence and corroboration through the use of different data sources and methods"

(Bowen 2009, p.3)

In this study my research aim was to explore mental health promotion through the ideas and practice of the main health professionals who supported and worked in partnership with parents. As a qualitative researcher, with Bowen's (2009) imperative, above, utmost in mind, I needed to gain a second source or lens of mental health promotion in the Tasmanian midwifery and child health nursing services and so decided that a second source of data would be the documents that guided these health professionals in their education and support of parents. In order to do this, I sought access through the directors of each service and their staff to materials regarding protocols, policies, brochures given to parents, clinical tools and assessments from the perinatal period and up to one year post birth. Thus, I was able to include another source of evidence, together with the rich and detailed data that

interviewing can bring, as a means of “combining methodologies in the study of the same phenomenon” (Bowen 2009 p. 291).

3.4 Coordinating the data

The second part of this chapter specifically describes the way the interview data and documents were collected in the study. In particular, this section outlines information about the participant interview recordings, the documents from WACS and CHAPS and any notes and memos that I recorded during the study.

3.4.1 Recordings

The first form of data collected was participant interviews. The interviews were conducted from October 2011 to September 2012. Each of the 31 interviews was recorded on a digital hand held recorder. The average interview lasted 44 minutes – the shortest at 33 minutes and the longest 93 minutes. Once I had introduced myself, reinforced what was included in the information letter and consent form, and my participant and I had sat down to talk, I then showed him/her the recorder and, again, after asking if each one was still happy to have the interview recorded, I started the machine and the interview began. Each interview was downloaded the same day to a password-protected server folder. I outsourced 17 interviews to be transcribed by a National (Australian) transcription company, and completed the other 14 myself. When the external transcriptions were completed, I reviewed them against the audio recordings in order to ensure that they had been transcribed correctly as some terminology may have been unclear to the transcriber. This data still remains within this server folder and will be destroyed within the timeframe as specified in the approved ethics application.

3.4.2 Documents

Documents pertaining to perinatal education were first collected state-wide from each of the three maternity hospitals and from a central repository (head office) for child health nursing. This collection was achieved through maternity service

managers and/or parenting education midwives taking me through what they utilised. Child health nursing policies and protocols were sent via email to me by the director of child health nursing. I also made the decision to collect as much data as possible that would give me a thorough understanding of what was available for and offered to parents in both maternity wards and child health clinics. Hence, as I visited each child health clinic and maternity ward/service for interviews, I also collected documents that were available to parents at these sites. Therefore, my data collection for document analysis included perinatal education lesson plans, clinical pathways, outline of classes or topics to be taught, both national and state government parenting brochures, and a number of policies and protocols pertaining to midwifery and child health nursing. The hard copy data was secured in a locked cabinet; the emailed documents in a password protected server folder.

3.4.3 Notes and memos

As a minor form of participant observation of midwifery and child health nursing practices, this final form of data collection involved broad, reflective notes about my own experiences of mental health promotion over the previous ten years in clinical practice in perinatal education. In doing so, I felt that I had incorporated my “turning back” from when the idea for the study was first conceived (Babcock 1980). These notes were created during the first year of my PhD enrolment in which I reflected upon the assumptions I had that questioned why mental health promotion was not discussed in any significant way in perinatal education. Over that first year, I also discussed my thoughts with my academic colleagues: both midwives and child health nurses, and kept broad notes of their thoughts as a form of preliminary jottings for my study.

As explained in the previous section, I had an initial round of meetings with directors and regional managers early in my candidature to discuss my study. I wanted to determine their level of interest and support for my research – whether it seemed logical and of worth to their services, particularly bearing in mind my purpose involved a change agenda (if needed) in perinatal education. From these meetings, I kept field notes of their comments. I also reflected significantly on their answers and my responses to them. In doing so I gained an insight into how my questions would

need to be shaped. I also found that in taking these notes from these meetings there were certain issues to do with the history of the two services that were specific to Tasmania (such as changes in geographical boundaries and leadership) that were important in helping me to ‘get in’ (Fontana & Frey 2008) with my participants and establish an air of collegiality as a non-Tasmanian.

Immediately after each interview, I also made brief journal entries regarding how I felt the interview went – my initial reactions to the participant when I met them, the atmosphere of the interview itself, how I felt my interviewing style went and how my questions were understood. These notes were helpful in adjusting any misunderstandings within my semi-structured interview questions when conducting the subsequent interviews and when analysing my interview data.

3.5 Analysing the data

The third part of this chapter specifically describes how the data were analysed in this study. In particular, this part outlines the interview analysis, the document analysis process and how the memos and notes were used within the analysis process.

3.5.1 Interview analysis process

Before I began my analysis of my participants’ interview recordings, I deliberated upon which process would best align with my research aim. I decided upon a theoretical, thematic analysis as described by Braun and Clarke’s (2006) and was able to use this method to identify, analyse, and report the patterns or themes within my interview data (p.6). Braun and Clarke (2006) also state that one of the benefits of thematic analysis is its flexibility which potentially allows for a rich and detailed, yet complex account of data (pp.4-5). However, what is important in that flexibility is that researchers make their (epistemological and other) assumptions explicit (Holloway & Todres, 2003). My focus, in using thematic analysis, was to determine similarities or common themes of the participants, rather than highlight exceptions or differences in perceptions.

With this caution in mind and due to my critical stance, what was very clear to me from the outset was that there would not be any passive identification of emerging themes from my data; I would be very active in selecting which key ideas and themes were of interest (Taylor & Ussher, 2001). Furthermore, I would be using inductive reasoning to work out the relationships between related concepts and then endeavour “to place back this new knowledge into previously developed knowledge” (Harding & Whitehead 2006 p.142). What was also important was that I needed a “decision trail” (Sandelowski 1986, p.2) in order to invite the reader to examine trustworthiness in my process (Rolfe 2006). However, what was most clear to me was that I was “deeply and unavoidably implicated” (Sandelowski & Barroso 2002, p.2) in my co-construction of the data with my knowledge and beliefs playing a significant role in the interpretation thereof. My thematic analysis was theoretical as the analysis process was driven by my analytical interest in mental health promotion and thus explicitly analyst-driven. This meant that my findings would be explained less in a rich description of my data overall, and more through detailed analysis of how the data addressed my research question (Braun & Clarke 2006 p.12).

I presented these initial thoughts to my supervisors who confirmed these preliminary views when we met to discuss the selected process. My supervisors were integral to the study’s trustworthiness and credibility in that potential bias (mine) was diminished through their involvement in the initial planning stages of analysis of both forms of data. They were engaged with undertaking some preliminary analysis with a sample of interviews within analysis meetings (face-to-face, phone or email) to confirm agreement with my interpretation. I explained to my supervisors how my study’s critical ethnographic ‘value laden’ approach would influence how I analysed my data. In doing so, I discussed Thomas’s (1993) and Madison’s (2012) guidance regarding how this approach’s lens would behoove me to consider not so much what is being revealed, but at another level, what the data could be saying, and certainly to then consider what implications for change there were. I knew that “giving voice” to mental health promotion through my participants’ responses involved my “carving out unacknowledged pieces of their narrative evidence by selecting and editing in order to deploy them to border my arguments” (Fine 2002, p.218).

I then decided upon a systematic process incorporating two major issues that were very important to my approach. Firstly I wanted to ensure that each participant's interview did not become fragmented and that I continued to view the interview and the participant as a whole. This meant that I did not want a process of taking snippets of information and placing them into a pile with like phrases/words from other interviews for similar content. This also meant that any use of data analysis computer programmes, such as N-vivo, which tend to confer a 'one fits all', dominant analysis process (Coffey & Atkinson 1996), was considered and ultimately discarded. I wanted to ensure that I began and ended the process of analysis with the interview intact yet where I could be satisfied that I had read the interview and gleaned as much as possible in the way of common themes. Secondly, in order to ensure that I remained focused on the interview transcript under analysis, I decided that I would go from beginning to end of the analysis process (as described below) with one interview before commencing the next interview's analysis.

Therefore, in order to acknowledge these key priorities of avoiding fragmentation and continuity, I decided upon an initial three step process that involved a progression from description, where the data were analysed to show patterns in semantic content, to interpretation, where I attempted to group the data according to their significance regarding mental health promotion, to broader meanings and implications for my research question (Patton, 1990). Finally, in moving beyond the semantic content of the data, I identified and examined any underlying ideas, assumptions, conceptualisations and ideologies that could have shaped or informed the semantic content of the data (Braun & Clarke 2006 p.13). In this process I mirrored Mason's (2002) approach of reading data in three ways: "literally" (what is said in the content and structure of participant responses); "interpretively" (reading "through or beyond the data", p.149); and "reflexively" (my role in the process of data analysis).

More specifically, I *first* read through each interview transcript, simultaneously listening to the audio of the participant being interviewed. I then listened again to the transcripts to immerse myself in the data and noted any paralanguage (e.g. hesitation, sighing) that may have been lost in the written transcript. I then notated in the left hand margin of the transcript, one or two words to describe the content – sometimes

even using the participants' words i.e. *'no damn money'* or *'political rhetoric'*. Once I had completed this step with each interview, I moved on to the next one.

Secondly, I then re-read and re-listened to the interview, making notations in the right hand margin, noting what the words in the left hand margin represented (Braun & Clarke 2006). An example of this included: *'no damn money'* as an example of *'lack of funding'* (or *'frustration with workload'* depending on the context). Keeping the interview intact helped to minimise any loss or misappropriation of this context of the participants' words.

Thirdly, I created a page entitled 'summary page'. On this summary page I recorded, in the first instance, an 'affective' view of the interview, noting any thoughts I had written down after the interview as memos, or gained from listening to the interview soon after it was completed. This stage noted any relevant details such as *'participant passionate about this area'*, *'midwife trying to get her lunch and the interview done together'*. There were other details too such as where the interview took place, noise factors, interruptions, easy flow of discussion, chronological order of interview and how my interviews skills modified as time went on; not in any precise way, just as the thoughts came and where they indicated an importance for that particular interview. On the summary page, in the second instance, I also wrote a list of key ideas that I believed came out of the interview from re-listening to it and also from the right hand margin notes that answered 'what is this an example of?'

In summary, I dealt with each transcript as a discrete source in a three step process: a first reading for a literal summary; a second reading for topics beyond the data; and a third for a holistic summary with a reflection of the interview itself and a list of key ideas. Furthermore, I understood that the analytic process was more recursive and developed over time and should not be rushed (Ely et al. 1997; Braun & Clarke 2006 p.16; Mason 2002, p.149).

The next stage in my analysis process following the 'coding' or 'reading' of my data related to the identification of themes. In this next process, I actively (Thomas 1993; Taylor & Ussher 2001) identified key ideas and which themes were occurring. Braun and Clarke (2006) state that a theme captures something important about the data in relation to the research question, and represents some level of patterned response or

meaning within the data and that researcher judgement is necessary to determine what a theme is (p.10). I initially considered that my themes would be recognisable due to the sheer number of responses I saw in the data around each key idea. However, Braun and Clarke (2006) maintain that a theme is not necessarily dependent on quantifiable measures, but in terms of whether it captures something important in relation to the overall research question (p.10). Thus, what was important was that the flexibility of thematic analysis allowed me to determine my themes in a number of ways. Of greatest importance was that I needed to be consistent in how I did this (Braun & Clarke 2006 p.11).

I initially identified fifteen subthemes, and with further analysis these fifteen were condensed to three major, over-arching ones. This reduction occurred when I went through my data reviewing again and selected quotations from each interview for each of the subthemes in order to see what was supporting them. It then became easier to ascertain the essence of each quotation. Then, with my research aim and research question in mind, I was able to interpret the broader issues that the participant responses were reflecting. Finally, it was then a case of working through each subtheme and deciding into which overarching theme it best fitted. Patton (1990) discusses a process of deciding how the patterns I saw became themes through two criteria: internal homogeneity and external heterogeneity. In the former I needed to ensure that the data adhered or “dovetailed” in a meaningful way (internal homogeneity). Secondly I needed to safeguard “clear and bold differences across individual themes” (p.403).

In summary, the process of analysing my interview data was guided, for the most part, by Braun and Clark’s (2006) suggested framework for thematic analysis. Notably from this analysis, fifteen subthemes merged into three overarching themes: complexity of mental health, a mental illness default framework in practice and barriers to mental health promotion.

3.5.2 Document content analysis process

My second form of data analysis was content analysis of the collected documents. Bryman (2004) defines document content analysis as a “systematic procedure for

searching out underlying themes in reviewing or evaluating documents” (p.392). He asserts that, like other analytical methods in qualitative research, this analysis requires that data be examined and interpreted in order to elicit meaning and understanding. Furthermore, the aim of document content analysis is to be systematic and analytic but not rigid (Altheide 1996, p.16). Bowen (2009) maintains that documents which contain text (words) and images have been recorded or published without a researcher’s intervention. What I understand this to mean is that I was not involved in the construction of the documents – as opposed to my construction of the interview questions and my part in the co-construction of data from the interviews – allowing for some distance. However, as I was actively involved in the interpretation and analysis of these data, I still played a part in the construction of my findings although to a lesser degree.

Atkinson and Coffey (1997) refer to documents as ‘social facts’, which are produced, shared, and used in socially organised ways (p.47). As a midwife and child health nurse, I assumed that the documents or ‘social facts’ that I gained access to would be in the form of printed sheets of information, booklets compiled for various areas of perinatal education, manuals, policies, protocols, books, event programmes, lesson plans, education syllabi, specific forms used in clinical work (such as clinical pathways and psychoassessment tools), and the like. I originally considered restricting my collection of data mainly to lesson plans (assuming there were any) and parenting curricula (again assuming they were in existence) as, initially, I was solely interested in antenatal classes and child health anticipatory guidance. However, in order to gain a thorough understanding of the role of mental health promotion in the perinatal period, as opposed to early detection, prevention or onward referral, I needed to look at as many materials as possible, and so a large collection of data was sought.

Furthermore, I was mindful of Bowen’s (2009) discussion regarding an absence of sufficient detail in most studies in reviewed literature, regarding the procedure followed and the outcomes of the analyses of documents. By ‘casting a wide net’ for the data collection, I hoped to gain as much information as possible in order to be representative of the services I examined. Atkinson and Coffey (1997; 2004) advise researchers to consider carefully whether and how documents can serve particular

research purposes. Therefore, it was important not only to be meticulous in my collection procedures, analysis and interpretation of the data, but also to ensure that the recommendations from the study be reported back to WACS and CHAPS for any changes (should any be necessary) that could be important for parents' wellbeing. In doing so, I would also be remaining congruent to my critical ethnographic approach of ensuring that my work not only explored my research question, but that the findings translated into supporting parental rights to mental wellbeing.

Although documents can be a rich source of data, it is important not to treat them as "necessarily precise, accurate, or complete recordings of events that have occurred" (Bowen 2009, p.6). His comments cautioned me to ensure that I did not simply 'lift' words and passages from available documents but that I established the meaning of the document and its contribution to the research aim being explored (p.4). It was also important to determine the relevance of documents to my research question and aim (Bryman 2004) and that I "ascertained whether the content of the documents fitted the conceptual framework of my study" (Bowen 2009, p.4). In doing so I determined the authenticity, credibility, accuracy, and representativeness of all the selected documents I collected.

In my document analysis process, I was guided by a number of studies; firstly by Altheide (2004) whose approach to ethnographic content analysis advocates for a familiarisation with the context within which the documents were generated, then to becoming familiar with a small number of documents, and finally to generating some categories (using similar terms to those in my literature review). In this study, the document content analysis was an iterative process that combined elements of content analysis and the thematic analysis that was applied in the interview analysis process.

Firstly, the documents I collected were assessed for completeness, in the sense of being comprehensive (covering the topic completely or broadly) or selective (covering only some aspects of the topic) (Bowen 2009). Once I had completed this, I determined whether the documents were even (balanced) or uneven (containing great detail on some aspects of the subject and little or nothing on other aspects). Further steps in the process, which I recorded in an excel spreadsheet, included the

need for me to consider the original purpose of the document, that is the reason it was produced and its target audience. It was also important for reasons of context and authenticity to know information about the author of the document and the original sources of information from which the documents were constructed. Overall, although I cast a wide net, there was not a large amount of data to collect.

Documents related, mainly, to protocols that the midwives and child health nurses used in their day to day practice. Once I had started analysing each protocol (e.g. clinical pathway, databases records, assessment tools) for mental health promotional content, I found that there were some absences or sparseness of content, which Bowen (2009) maintains could be suggestive of something significant to note about mental health promotional information or the health professionals involved or even the context in which they find themselves. Furthermore, this absence or dearth of information may have been suggestive that certain matters had been given little attention or that certain voices have not been heard (p.8).

One of the other purposes of document analysis that was important to recognise was what Bowen (2009) calls a document's ability to provide context. By this he means how documents can 'bear witness' to past events and provide background information as well as historical insight. In keeping with my study's critical ethnographic lens, this information and insight helped me to understand the historical roots of the documents I collected and indicated past conditions that impinged upon how mental health promotion was or wasn't included in early parenting. Lastly, as documents can provide a means of tracking change and development, Bowen (2009) advises that where various drafts of a particular document could be accessible, that I compare them to identify the changes as even subtle changes in a draft can be reflective of substantive developments in the area.

In summary, my second form of data was documents that I collected from the WACS and CHAPS. In my analysis process I related the process to my research question "*what creates mental health?*" noting any form of mental health promotional content within all documents available. The findings from this analysis process is presented and discussed in the second combined findings/discussion chapter regarding a default mental illness framework in practice, entitled '*The elephant in the boa constrictor*'.

3.5.3 Memos and notes

A final note regarding data collection involves the memos and notes I wrote as explained in my description of a minor participant observation methodology. The majority of reflective note-taking supported the process of designing the interview questions and supported change to my interviewing style where needed. However, my notes also were part of my interview data analysis as they gave me a first impression (first stage of the initial three stage process) to include in my analysis process.

In summary, this section has explained the two methodological strategies of interviewing and document content analysis employed in this study. In doing so, the process of preparing for the study (setting the scene), collecting the data and analysing the data have been clarified.

3.6 Reflexivity

Reflexivity requires an awareness of the researcher's contribution to the construction of meanings throughout the research process, and an acknowledgment of the impossibility of remaining 'outside of' one's subject matter while conducting research. Reflexivity then, urges us to explore the ways in which a researcher's involvement with a particular study influences, acts upon and informs such research.

(Nightingale & Cromby 1999 p.228)

In this final section of my method chapter, I acquaint the reader with the questions that were used in the semi-structured interviews together with an account of how the questions were formed. In doing so, it is the aim of this section to confront reflexivity. As a researcher using a critical ethnographic approach, it is incumbent upon me to justify how and why I formed these questions and to proffer understandings of my assumptions regarding the interview data. In doing so, I explain another step in revealing how the interpretation of data was performed. My goal in discussing my assumptions is also to proffer my accountability for my “position of authority” as researcher and a “moral responsibility to representation and interpretation” (Madison 2012 p.8). In this section I reintroduce the participants,

briefly described in *Chapter One*, and restate my research question. I then discuss the formation of the interviews' *broad* questions, after which I present my assumptions. Following this, I present the development of the interview's *focussed* questions together with my assumptions.

Participants

Thirty one participants were interviewed for this study. In total, 18 community child health nurses and 13 registered hospital midwives gave their consent to take part in a co-constructed, one-on-one, face-to-face interview in which five broad questions and six focussed questions were discussed. There are three main regions that comprise Tasmania and all regions were represented within the study. The child health nurses were distributed widely throughout the three regions: nine in the North, four in the South and five in the North West, whereas the midwives were situated within the three public hospitals in Tasmania; with ten participants in the capital city in the South, two in a North West hospital and one in the North.

The majority of child health nurses interviewed held a midwifery qualification, whether currently registered or not – as this was a requirement in the past, in order for a person to be able to undertake studies in child health. Seven of the midwives interviewed held a child health nurse qualification, and had worked in the area of child health but had returned to midwifery.

The interview questions were designed to elicit the participants' knowledge around early parenting mental health promotion and to answer my research question:

“What do midwives and child health nurses consider ‘creates mental health’ in the perinatal period?”

This question was based on Antonovsky's (1979) question pertaining to a Salutogenic orientation, as opposed to a pathological one which might question “what creates mental illness in parenting?” My sub-question was borne out of the need to ascertain answers to this question by firstly going to the health providers who work most closely with parents in the perinatal period (conception to the end of the first 12 months):

“How do midwives and child health nurses understand mental health promotion and how do they implement it in their practice?”

3.6.1 Formation of interview questions

From my reading over many years of all things protective for mental wellbeing and staying well, coupled with my experiences as a child health nurse and midwife – and incorporating the literature review for this study – I knew that my questions would be constructed out of intuition and anecdotal experience that the area of mental health promotion was not receiving broad coverage by health professionals in the parenting area. I had some ideas why this might be: selective primary health care as opposed to comprehensive; the burden of mental illness and the need for early detection and treatment as opposed to prevention and funding that requires short term, quantifiable outcomes. So, given these assumptions and the need to remain congruent with my critical lens, I created nine questions for discussion that I considered invited the participants to look critically and reflexively at the foundations of their practice in mental health promotion.

I now outline these broad and focussed questions with the aim of explaining how and why they were created. I do this in order to be transparent about my assumptions but also to engage the reader in the journey about the importance of ‘why these questions?’, and the order in which they were used.

Formation of broad questions

I wanted to start the interview with a conversation regarding child health nursing and midwifery understandings of the broader terms or constructs of mental health promotion: mental health, health promotion and mental health promotion. Starting this way would give the participants time to warm to the area under exploration which would then support them when they made the application to their practice that the focussed questions demanded. The information letter (Appendix 3) that the participants had received prior to the interview contained a brief statement aim of the interview:

“This study aims to explore how midwives and child health nurses understand the term ‘mental health promotion...and to inform perinatal educational curricula regarding mental health promotion partially from data collected during the interviews with early parenting health professionals.”

My first question in the interview was ‘*What is your definition of mental health?*’

In asking this question I wanted to understand how the participants personally viewed this term – hence my asking for *their* definition – not a definition. I then asked them ‘*What are your thoughts regarding the terms ‘mental health’ as opposed to just ‘health’? (prompt – do we divide the terms and if so why?)*. In this question I was seeking to observe if they perceived that the terms were divided, if so why they were, and if possible to explore any historical or cultural reasons for the dualism. In asking this question, it helped me to see how they perceived mental health in the light of health.

Next, I asked ‘*What do you think ‘creates’ mental health?*’ based on Antonovsky’s question. From this question I was aiming to explore factors or elements that the participants considered may help people to stay well. Initially I asked the question stated above, but after the first few interviews, I realised that the sentence was being interpreted as ‘what causes mental illness?’ which I considered may also be influencing a mental illness inclination. I decided to ask Antonovsky’s question but also to explain further ‘what are the elements that you consider go to make up mental health or mental wellbeing?’ I also used at times the phrase ‘positive mental health’ (Jahoda 1958; Labonte 1990; Cook 2005) in order to ensure the participants knew the interview was not about mental illness.

The next two questions asked the participants about their understanding and description of health promotion and mental health promotion: ‘*What is your understanding of health promotion? Tell me how you would describe mental health promotion?*’ Sometimes these two questions were one and the same for some participants who saw no division between health and mental health, that is, something that was indicated in their answers to the first two questions. In asking these questions, I wanted to explore their knowledge and ideas of health promotion and directed them to illustrate their understanding in the parenting field if that was helpful in answering.

Assumptions and some description of answers to the broad questions

Overall, I had assumed that the majority of participants would describe mental health as mental illness, or at the very least, that they would not be able to clearly differentiate between pathological and Salutogenic models. These assumptions were based on my experience in the child health and midwifery sphere in Western Australia where the role of mental health promotion was predicated upon ensuring that PND was screened for (early detection) and support and treatment offered.

Regarding the second question, the participants indicated that there should not be a divided term and that health should be looked at holistically. However, they stated that a divide did exist. When I asked why they thought that there was a divide between mental health and health – I began to perceive a changed response to the description of the term mental health. Mental health in the first question (personal definition) showed a movement away from defining mental health as an illness, particularly in child health nurse participants. However, in the second question, mental health was starting to be redefined as mental illness and health as being physical illness. I began to reflect from this point whether terminology used and the framework in which we work could be influencing our practice?

In asking the participants ‘*What creates mental health?*’, I wondered whether this question would be a showcase for the participants to tell me about these elements and in doing so would detail how child health nurses and midwives understand what information is vital for parents to incorporate into their ‘sense of coherence’ (Antonovsky 1987). I indicated previously that my third question ‘what creates mental health?’ aimed to explore the elements that support wellbeing or emotional wellbeing in parents and that by the third interview, I understood very quickly that my terminology needed amending. I took somewhat for granted that my colleagues would understand Antonovsky’s meaning for ‘creates’. Given that I quickly realised that ‘creates’ was interpreted as ‘causes’ and that the question took on an ‘illness’ connotation – I amended the terminology to ‘elements that go to make up wellbeing’.

The final two broad questions revolved around health promotion. I had assumed, given their Department of Health and Human Services’ (DHHS) job descriptions claim the positions as working within a Primary Health Care framework, that both

midwives and child health nurses would have a firm understanding of health promotion – using WHO or the Ottawa Charter as a basis for examples. Three participants noted the Ottawa Charter’s position on *access* and *advocacy for the family*. The majority responded that health promotion, in its entirety, is health education *eat well or get exercise* or awareness raising programmes. Although I had also initially assumed that many of them would see health and mental health promotion as one and the same, (especially those who had indicated as much in question two about division or dualism), most described mental health promotion as PND symptomology awareness raising and obtaining support for those who were unwell.

I had assumed a greater, broader understanding of health promotion than the participants gave. However, I was not surprised either by the findings. Frequently – as midwives and child health nurses – my colleagues and I would consider that our areas embody health promotion, and certainly participant responses in this study replicate this understanding; that they consider they are talking about a broad health promotional context. In contrast, in my work experience, I have seen few, if any, policies or protocols that enforce this embodiment. Advocacy, mediation and enabling (WHO CPHA 1986) are certainly well embedded in our practice in supportive mechanisms of early detection, treatment advice and health education. However, building public policy, creating supportive environments and engaging in a deeply, interactive way with the community, as Arnstein describes in her ladder of participation’s citizen power (1969), seem to be lacking. My experiences and the findings of this question denote a gap between our knowledge of health promotion, that is, the broader boundaries of health promotion and how it is engendered. Could these two, final, broad questions be exposing a potential gap between the knowledge of health promotion that is gained through child health and midwifery education but is then lost in implementation due to workplace structure?

Following on from a collection of broad responses to the constructs under exploration in this study, I created more focussed questions in order to explore how the midwives and child health nurses had formed this knowledge and about their personal practice of mental health promotion.

Formation of focused questions

My first focused question involved the following dialogue:

‘Going back to your thoughts re mental health and health promotion – I am interested to know how midwives/child health nurses gain their ideas and knowledge – how they have constructed their practice – Can you tell me where your knowledge has come from re mental health? mental health promotion? (prompts – education, experience, world view, healthcare system structure and funding).

In asking this question I wanted to gain an understanding of how the participants constructed their ideas around mental health promotion: the origins for their answers to the broad questions. This was a significant question for me to include as my critical lens behove me to understand the ‘why’ of practice as opposed to the ‘what’ in practice. In asking about construction of practice, I believed I would gain this understanding – and be able to consider the ‘so what’ of mental health promotion in parenting: is it significant to the participants? If so, why is it significant to those who provide care for parents? What motivates the participants to discuss mental health promotion?

My next focussed question asked participants to tell me about *‘some examples of mental health promotion that you have experienced/taught etc.’* In asking this question I was aiming to better understand what parents were receiving from midwives and child health nurses regarding mental health promotion. I was collecting documents from WACS and CHAPS to analyse for mental health promotional content in a broad context. However, it was my intention that this interview question would help me highlight a number of examples utilised by the people who worked most closely with parents; that they would tell me the what, the how and possibly the why of mental health promotion for parenting.

Following this question of what they had experienced or used, I asked *‘what are some of the structures within the WACS/CHAPS (policies or protocols) that support you in discussing or implementing mental health promotion for parents?’* in order to clarify anything they may have missed in the previous question. This question also helped to explore further the role of the service in which they worked, as well as participant thoughts about the policies and protocols for mental health promotion. This question’s emphasis was on the word ‘supporting’ mental health promotion as

opposed to limiting mental health promotion in their practice. In order to obtain a full picture, the next question then asked them about any barriers to mental health promotion: *‘what barriers within the work structure have you experienced that might hinder this promotion?’*

My penultimate question asked the so called ‘miracle’ question wherein unlimited money and the like is offered to the participant in order for them to be able to transact a scenario placed before them: *If you had unlimited funding..., if you were able to wave a magic wand – what would parenting mental health promotion look like to you for parents? For the wider community?* This question was a vital inclusion in order to ascertain how the participants understood the previous questions regarding mental health promotion. What I mean by this is that there could be some ideas about an issue – say mental health promotion – yet they may be of a more superficial understanding, or contain surface knowledge. An interview can capture these understandings and perhaps miss that the knowledge may not be deeply grounded. To ask the participants to cast a wide net within the construct of mental health promotion and ‘to go for broke’ regarding how they would change or adapt their situation to explore mental health promotion I believed asked for a deeper understanding and synthesis of this construct.

My final question asked the participants to change roles with their clients and put themselves in the role of the parent: *‘what do you consider mental health promotion to mean to parents in the perinatal period?’* I gave the participants a scenario whereby I was a parent and if they were to ask me what mental health promotion or wellbeing meant to me – what would I say to them? I wanted to include this question as a final connection for the participant to link the parent into the interview and to mental health promotion. In asking this question, I specifically wanted to see if the parent had been asked about their needs in this area; whether the parent had been engaged and participated in the process of designing their own mental health promotion as much as this primary care process (WACS and CHAPS) could achieve.

Assumptions and some description of answers to the focussed questions

I had fewer assumptions about the more focussed questions, as I was more interested in how each participant practised in his/her own individual way, as opposed to broad understandings from the first part of the interview. More importantly, this next part of the interview drew its currency from the answers to the broad questions: the warm up had produced a filter for the participants' responses and a pool of ideas from the co-construction of the interview for them to continue to define and redefine their responses to this next set of questions.

Important to note again is that mental health promotion was interpreted by over three quarters of the participants as mental illness, hence personal experience sometimes reverted to mental illness experience. In this question, I did continue to endeavour to guide the participants to consider mental health promotion as wellbeing promotion or promotion of the 'capacity that exists' (Pollett 2007, p.1). However, the default position came from their broad question responses (as they were describing how they constructed their notions of mental health promotion) and so I felt that to do so more strenuously would be attempting to influence them and be in breach of their chosen positioning.

After exploring the participants' constructions of their practice; finding out the 'so what' that could motivate them to discuss or provide mental health promotion, my next question asked them to describe some examples of mental health promotion at work. Due to my extensive education in communication whilst working as a child health nurse, I had assumed that many, and in particular the child health nurses, would list communication and a trust relationship as important tools or practices for mental health promotion.

For all participants, the questions regarding supports and limitations of mental health promotion within the workplace received the most detailed responses within the focussed questions – and in particular limitations to mental health promotion. I had assumed that the issue of '*inadequate time*' would be raised frequently. However, I was surprised by the number of issues that were discussed as being unsupportive of mental health promotion.

The next question was the so called 'miracle' question of offering the participant unlimited funds to build mental health promotion in their workplace and in the community. My assumptions were again that although both services claimed to work within a Primary Health Care framework, I was sceptical that connections would be

made to the wider implications of what could be achieved with unlimited funding. Primary Health Care has within its tenets that it is not bound by the silo of health but is intersectoral in nature.

The final question asked the midwives and child health nurses to describe what they thought mental health promotion or emotional wellbeing meant to parents. My assumptions about this question involved a perception of a top-down approach to healthcare delivery in parenting. Midwifery and child health courses are renowned for a framework that emphasises a woman or family centred approach, respectively (AHPRA 2012). Part of this approach demands an engagement of the woman or family in designing their care. However, my lived experience is that the client is more invited into a token engagement only (Arnstein 1969) and that the healthcare system's structure and delivery are too rigid for two way participation.

In summary, in this section I have considered Madison's charge "to discuss our positionality as ethnographers and as those who represent Others" (2012 p.7). In discussing my assumptions I have sought to be reflexive and to expose that which Noblit, Flores and Murillo (2004) call a lack of focus on the researcher's own role in the study. In doing so, I have also aimed to present my questions with analysis as a way of making explicit self-awareness within my positioning, thus, revealing my acts of study in order to lessen what could be interpreted as domination over participants and their responses (Noblit, Flores & Murillo 2004, p.3).

3.7 Conclusion

This chapter has presented the method and methodology utilised in this study of early parenting mental health promotion. The study embraced critical theory as its foundation and a qualitative, critical ethnographic approach as its implementation. The methodologies of interviewing and document analysis were performed to gather the data for this study. The processes of preparation, collection and analysis of these two methodologies were described in this chapter within which ethics considerations such as privacy, confidentiality, credibility and trustworthiness were discussed. In order to ensure transferability of my findings, I maintained a detailed account of questions, assumptions, participant details, culture and context so that a reader will be able to

decide between elements of the study and his/her own experiences (Guba & Lincoln 2005).”This Method chapter ended with a presentation of reflexivity through an examination of the development of the interview questions.

Introduction to findings/discussion chapters

The following three findings/discussion chapters represent the three overarching themes interpreted from the interviews and document analysis: 1) Complexity of mental health, 2) Default mental illness framework, and 3) Barriers to mental health promotion. Each chapter begins with an allegory based on my earlier school and university studies (Bachelor of Arts) in English literature and European languages. I do this as a way of understanding and expressing the complex concepts within. Each allegory is representative of the theme each chapter illustrates. Each findings/discussion chapter represents one of the three themes and within each theme are a number of subthemes and concepts.

Each chapter includes an introduction to the theme and then presents the findings through the subsequent subthemes and concepts with supporting quotes from participants included in italics. Each chapter discusses findings interspersed with discussions from literature that support or refute the themes that emerged in this study of early parenting mental health promotion. The table below provides a visual representation of the themes, subthemes and concepts for purposes of clarity and is included with particular emphasis of shading for each chapter after each introduction.

TABLE 2: Layout of Findings/Discussions Chapters

Chapter Four

Much ado about nothing?

MAJOR THEME	SUBTHEMES	CONCEPTS
Complexity of mental health	Defining mental health	Consternation
		Confusion
	Complexity of mental health promotion in practice	Screening
		Raising awareness
		Illness awareness

Explaining the complexity of mental health promotion	Stigma of mental illness
	The complex scope mental health

Chapter Five

The elephant in the boa constrictor

MAJOR THEME	SUBTHEMES	CONCEPTS
Default mental illness framework	Participant practice embedded in a mental illness framework	Risk factors
		(Mental) health promotion
		Knowledge construction of mental health promotion
		Workplace structure
	Policies and protocols embedded in a mental illness framework	Anticipatory guidance
		Family/psychosocial assessments
		Edinburgh Postnatal Depression Scale (EPDS)
		Perinatal depression resources
		ObstetriX
		Child health surveillance
		Antenatal parenting classes

Chapter Six

Complicit?

MAJOR THEME	SUBTHEMES	CONCEPTS
Barriers to mental health promotion	Inadequate communication	Barriers to building therapeutic relationships
		Barriers to communicating with parents
	Inadequate time	
	Medical influence	
	Incongruent models of care	Workforce barriers
		Target platform
		Inadequate funding

The findings/discussion chapters are combined as I considered it vital to keep the findings with their related discussion as they both informed each other. In keeping the findings and discussions together I was reinforcing Kingwell's notion that "we can say what things mean, one at a time and with close attention to the details of context, but we cannot say what it all means, because the question does not really arise meaning-fully" (2001, p.38). However, through this combining, there were instances of overlap between themes as it was difficult to deal with all concepts discretely. I have made mention of this where it occurs.

As a final note of transparency, I acknowledge that I have analysed the data of midwives and child health nurses together, as opposed to two distinct services. I did this as my motivation for analysing both services was due to their contact with parents in the perinatal period, the period of most contact with midwives/child health nurses. Again, I believed that "the whole is greater than the sum of its parts" (Aristotle) and the context of parenting was the most important consideration, not the specifics of the roles of midwife or child health nurse. However, I have at times, in the following three chapters, separated the findings of midwives from child health nurses where they pertain to specific findings that could only occur to a midwife or a child health nurse. For purposes of clarity, each participant's response has a number that was selected to explain a finding within each of the three chapters, to represent his/her interview. I also state whether he or she is a midwife (M) or child health nurse (CHN). An example of this is *no damn money!* (1CHN).

Chapter 4

Findings and discussion: Complex understandings of mental health

Much ado about nothing?

*Marry, sir, they have committed false report;
moreover, they have spoken untruths;
secondarily, they are slanders;
sixth and lastly, they have belied a lady;
thirdly, they have verified unjust things;
and, to conclude, they are lying knaves.*

Dogberry

Shakespeare, *Much ado about nothing* V, 1, 2218.

Dogberry is the chief constable and leader of the town night watch in Messina, Italy where the action of Shakespeare's play takes place. His frequent, comedic malapropisms are renowned and a joy to hear, if you enjoy Shakespeare. I am not suggesting that mental health promotion is in any way jocular by linking the Bard's comedy to my study. However, I do find that Dogberry's many ways of describing 'false report' cause me to reflect on the confusion of mental health terminologies, their meanings and implications for midwifery and child health nursing. The issues in Shakespeare's play that strike me as similar to those in mental health promotion are the contested use of words and meanings and whether there is a more serious consequence to their usage. We, the audience to Shakespeare's comedy, laugh as Dogberry gives his report to Leonarto about the rogues Borachio and Conrade, but we nevertheless understand his meaning and are not too worried when Dogberry's 'piety' becomes 'impiety', or when he talks about someone being 'condemned and sent to everlasting redemption!' His malapropisms end up being 'much ado about nothing' in the play and thus it could be argued that making a case in this study for correct terminology might be to overplay the semantics of mental health or emotional health and/or mental wellbeing in parenting. However, my findings would suggest otherwise.

4.1 Introduction

This chapter entitled '*Much ado about nothing?*' presents the first of three combined findings and discussion chapters and considers the first theme 'Complex understandings of mental health'. In this chapter, these complex understandings relate to how participants perceived mental health and its linkages to mental health promotion. Within this first major theme are three subthemes: 1) defining mental health, 2) the complexity of mental health in practice, and 3) explaining the complexity of mental health. The first subtheme pertains to how participants experienced defining mental health in the interview; the second subtheme illustrates findings that centered on their understandings of mental health in practice. The third subtheme confirms why mental health appears to be complex for midwives and child health nurses. Each finding within the subthemes suggests potential implications for practice and is followed by a discussion.

4.2 Defining mental health

This first subtheme presents the finding that midwives and child health nurses found defining, or giving their understanding of mental health very complex. There are two concepts within this subtheme: 1) consternation, and 2) confusion.

MAJOR THEME	SUBTHEMES	CONCEPTS
Complexity of mental health	Defining mental health	Consternation
		Confusion
	Complexity of mental health promotion in practice	Screening
		Raising awareness
		Illness awareness
	Explaining the complexity of mental health promotion	Stigma of mental illness
		The complex scope mental health

The first time it became apparent that mental health was an essentially contested concept (Gallie 1956) was at the beginning of each interview when each participant explained their definition or understanding – what mental health meant to them.

4.2.1 Consternation

As the midwives and child health nurses began, it was clear this first question about a definition or understanding caused some disquiet, in the sense of paralingual communication of deep sighs, groans and laughter, and also in the silences that imparted to me a sense of the participants being confronted with a complex task: *(groans)...well...mmmm (breathing out in a long sigh) (1CHN); Oh, that's rotten, Robyn! I don't know that I have a definition of mental health. I don't know... (8CHN); That's hard really (laughing) (3CHN); Oh Gosh! (laugh) well...I'm just trying to think...the stuff... this is straight off the top of my head (laugh) (22M); Oh, that's a hard one Robyn! (laugh) Yeah, "mental health"; I guess it's a state of, well... I don't know (14M)*. As I watched each participant, I also reflected that I was seeing deep contemplation; that all participants thought this to be a very serious question and one that needed much reflection. For example, one midwife responded after a long pause with *how you manage to get through the day, how you live your life (2M)*. A child health nurse, again after a long pause, shared *that's a hard one. I was thinking how you feel in yourself, how you feel in your head, in your emotions. But so many other things come into account with that (5CHN)*. For the majority of participants, this paralingual consternation or meta-communication was suggestive of underlying complexity of interpretation.

4.2.2 Confusion

Concomitant with the consternating comments, I considered that as the participants responded to the question, they also appeared somewhat confused when having to give their definition or understanding of the construct. Moreover, not only did the participants find the question difficult to answer, when they did answer, there were a number of different understandings given which indicated evidence of confusion and complexity. Examples of this confusion included one child health nurse describing mental health as ranging from *just your normal depression, to psychosis, to teary, to*

bluesy, to...it's a huge, it's just not one specific thing. Furthermore she maintained it's a whole range of issues, really, differing perceptions of different people and what they think of it as well (4CHN). A midwife stated that *by defining mental health it sort of defines some sort of framework of what illness...if you are looking at health or illness, what aspect of that you are refining.* She then added that *mental health really is more about the social and emotional and psychological health (22M).* Finally, a child health nurse commented *that's a tricky one* and then discussed her data assessment headings on the Child Health and Parenting Service (CHAPS) family assessment form in which *there's a mental health one. I think some things that they tell us to put under that don't actually fit... definition is really hard. Definition of mental health? I suppose, hey, that's really hard (9CHN).*

Further findings underline this complexity of defining terms. One midwife seemed confused about whether her definition of mental health needed to pertain to health or mental illness when she asked *you don't mean mental health as in sickness? When encouraged to consider wellbeing she countered you mean mental wellbeing?* followed by *when people look at their 24 hour day they obviously have ups and downs but generally, they are happy. That's what I would say would be mental wellbeing' (23M).* In this example, the participant asked me to guide her regarding defining mental health. However, in her response to wellbeing, there was still some ambiguity whether she was referring to illness or wellbeing. Another example, below, clarified defining mental health as moving between emotional and spiritual descriptors, to physical and then to illness treatment and support and was yet another illustration of indeterminate understanding of the construct:

mental health...so much more emotional, maybe spiritual, but altogether, isn't it...but also physical as well isn't? It is everything but I guess that when we are dealing with issues that relate to mental health we probably have to look at it differently... even though you can take medication, a lot of mental health is talking and supporting and that sort of stuff (24CHN).

An ambiguous example was from a midwife who discussed support in the first instance: *mental health is where you are helping to support someone.* Initially, this could have been suggestive of supportive discussions about wellbeing. However, the participant then identified illness *well, you are first of all trying to identify if there*

are any issues that you have regarding health, and regarding depression (28M) which arguably represented support as in treatment. In contrast to these above examples that combined wellness and illness, another child health nurse described a more holistic understanding of mental health that was more aligned with World Health Organisation (WHO) definitions when she stated that *I wouldn't be saying the absence of ill health, I'd be saying more around the sense of positivity and hopefulness and feeling in control and having a sense of purpose and making sense of the world (16CHN)*. However, the participants' perceptions around definitions of mental health and mental health promotion indicated an inability to determine illness or wellbeing.

In short, more child health nurses than midwives recognised certain protective factors (as discussed in *Chapter Two*) initially and described Ottawa Charter concepts of supportive environment and community engagement (WHO CPHA 1986) as underpinning their understanding of mental health promotion. However, for the main part, throughout each interview, 'mental health' was a consternating and confronting term that appeared not to be at the forefront of the participants' practice discourse. This confusion in terms is an important finding as it raises questions about why understandings of mental health continue to result in cognitive dissonance (Festinger 1957/62) for midwives and child health nurses.

4.2.3 Discussion

In this discussion section of the first subtheme 'Defining mental health' I will be looking at the literature that supports or refutes the issues of consternation and confusion in mental health definitions. Two questions drive this discussion: why the consternation and confusion initially and why did participants find the process of defining mental health complex? Moreover, why wasn't a definition of mental health at the foremost of participants' thinking as protocols (discussed in detail in *Chapter Five*) suggested it was an integral part of their practice. I did consider that in using the terminology 'define', it may be received by the participants as a test and so, perhaps it was this consternation of being put on the spot. However, as discussed in *Chapter Three –Methodology*, in the development of the interview questions, I was reassured that I countered this possible situation by asking them about their *personal*

definition or thoughts about what it meant to them – hence I considered that the questions around mental health definitions must be causing consternation and difficulties for another reason. Certainly, I reflected that had the midwives been asked to provide their definition of the third stage of labour, or the child health nurses their understandings of Piaget’s concrete operational milestones, then less dismayed and more direct and conclusive answers might have been offered.

The finding that mental health and mental health promotion were difficult to characterise is also well supported in the literature. There is a recognised confusion in describing these terms and many studies offer reasons. Firstly, there have been numerous definitions of ‘mental health’ and such a large number has obscured clarity (Secker 1998; Moodie 1999; Annor & Allen 2009; Payton 2009; Keyes 2010; Manderscheid 2011; Svedberg 2011). There are also the differences in values across countries, cultures, classes, and genders that can appear too great to allow a consensus on a definition (WHO 2001b; Sturgeon 2007). Furthermore, although many of these definitions contain particular insights, “none has been universally accepted, none can be called definitive, and none can fit all needs in all circumstances” (Moodie 1999, p.79). Therefore, it is significant to acknowledge that in defining mental health promotion there are two distinct positions (promotion and prevention) that impact upon how health promotion on the whole is portrayed and utilised. This dichotomy no doubt adds to the confusion as conceptual starting points for promotion and prevention differ and target divergent outcomes (Barry 2001).

The World Health Organisation (WHO) defines mental health as “a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community” (WHO 2001, p.1). This definition describes an attempt to move away from how mental health was previously explained as the absence of mental illness, with mental health promotion being somewhat controversially described by some (Royal College of Psychiatrists 1993) as “too nebulous or woolly to merit serious attention” (as cited in Secker 1998, p.59). Certainly, the beginnings of psychiatry influenced the direction of its development away from prevention (Sartorius & Henderson 1992). A review of more recent reports in the last ten years suggests any form of mental health promotion in the

perinatal area utilises primary, secondary and tertiary (recovery) prevention linkages with perinatal depression (NICE 2007, 2008, 2010; National Health and Medical Research Council (NHMRC) 2008; DHHS 2010; Beyondblue 2008) with few examples of the construct of health promotion (as opposed to early detection and prevention) being supportive of “the capacity that already exists” (Pollett 2007, p.1).

Furthermore, the issue of definition and use of the term ‘mental health’ as described by Donovan et al. (2007) below, suggests another reason why participants might have been confused when defining the term and giving a description of their thoughts – and when they did, the of midwives and child health nurses interviewed discussed perinatal depression or other psychiatric illnesses.

Mental health in the sense of good mental health is rarely thought about and talked about in the population at large. When ‘mental health’ is talked about or encountered (either in the media or among friends, relatives or acquaintances), it is mainly considered in the context of chronic mental illnesses.

(Donovan et al. 2007, p.54)

Donovan et al.’s (2007) discussion centres on the population at large. Child health nurses and midwives, as part of the population at large, are impacted upon by a variety of influences, including the understandings of parents with whom they engage on a day-to-day basis. As members of communities, midwives and child health nurses are affected by the issues around them and their communities’ impressions of mental health shape their understandings. When participants in this study were asked about their construction of their knowledge, many designated concepts such as Donovan’s (2007) population-wide understandings as being central to how they perceived their knowledge’s origins. In other words, they had learnt about their practice through working in partnership with parents (further discussion of the development of nurses’ practice is included in Chapter Five, section 5.2.5.).

The term ‘mental health’ has its origins in a diagnosis-focus of illness and it is only in more recent times that a more holistic, bio-ecological focus of person and his or her interaction with the environment and society has gained ascendancy (Manderscheid et al. 2000). However, earlier influences continue to befuddle researchers and consumers alike as it can be impossible when looking at papers and

reports to determine whether the terminology about mental health refers to health, illness or both together (Moodie 1999, p.79). Thus, it could be argued that participant midwives and child health nurses, whose ages averaged in the mid to late 40s and mid to late 50s respectively, have processed and utilised many trends of information over their years of work and that so much of this terminology, from so many different origins, has potentially left behind perplexity and contested meanings.

To this end, it is noteworthy to consider that the participant confusion or consternation could also be representative of how the term ‘mental health’ is reinforced by midwives and child health nurses within their roles. Confusion around the terms of mental health and mental health promotion may also be explained by the way the terms gain significance and meaning *from* the people who use it and by the way they use it (Moodie 1999) regardless of WHO’s direction. This conjecture obviously begs the question has the definition of mental health evolved from usage, or has usage formed its current definition in perinatal education? Furthermore, is it so important to have a single definition? I agree with Moodie’s (1999) stance against a ‘one size fits all definition’ and am not aiming in this study to offer a definition that will resolve the issue once and for all for midwives and child health nurses, and ultimately for parents. However, Moodie’s (1999) suggestion that a definition be an aid to communication is the issue when analysing the data in this study; that there needs to be some consensus about the use of whichever terminology by the group of people who work with parents, in order to synthesise the elements that support parents staying well throughout the perinatal period.

In short, the data demands, as a necessity, a consensus about how each term is understood within policies and protocols – not a one size fits all consensus, but an aid in communicating mental health promotion; one that aids a clear delineation between promotion and illness. In order to do so, there is a need to meet and discuss the history of the terms and work through how these terms were arrived at and why. Having these discussions will support understanding of where mental health converges within practice guidelines (Annor & Allen 2009). Such consensus would help ensure commonality of understandings and inform future development of these guidelines specifically for those who use them (midwives and child health nurses) and those upon whom these terms impact (parents).

4.2.4 Summary of defining mental health

In this subtheme of defining mental health, the first subtheme under the major theme of ‘Complex understandings of mental health’, I have discussed findings that pertain to confusion and consternation regarding the process of defining ‘mental health’, and have highlighted how a plethora of definitions could have led to this situation. I have also drawn attention to the argument that consistent, contested use of a term can lead to a reinforcement of confusion over time. In brief, participants found the term mental health hard to define and when they did, offered differing understandings and somewhat confused perspectives. Does this matter? It may not matter overly in Shakespeare’s play but I believe it does here. Svedberg (2011) argues that in healthcare the concept of health promotion needs to address the differences in the interpretation, as underlying values need to be exposed in order to understand what guides practice. I argue that it is the same regarding mental health promotion. When child health nurses and midwives work with parents and support them in their health, it is important to understand exactly ‘what’ is being supported. The way a concept is understood has implications for how it is researched in order to design evidence-based strategies within health services, such as the two Tasmanian services which are the focus of this study. ‘How’ and ‘where’ child health nurses and midwives use the term mental health and mental health promotion also has implications on many other fronts: for interpersonal communication between themselves and certainly this usage has implications for protocols and daily interactions with and guidance for parents.

4.3 The complexity of mental health promotion definitions in practice

In the previous concept I highlighted data that depicted participant consternation and confusion when defining the constructs of mental health and mental health promotion. The participants’ comments for the most part, indicated an intermingling of conflicted terminology at odds with explanations. This second subtheme under the major theme of ‘Complex understandings of mental health’, illustrates data representative of how mental health and mental health promotion definitions or understandings in perinatal education were understood and utilised by participants *in practice*. In doing so, this section foregrounds how the history and current usage of

mental health promotion (as determined by participants) in practice may have implications and consequences for parents who utilise the two services.

Through my analysis process three concepts were identified as comprising this second subtheme of the complexity of mental health promotion *understandings in practice*: i) screening, ii) raising awareness, and iii) mental illness awareness. These concepts suggest how these participant explanations of mental health promotion are utilised in practice within the midwifery and child health nursing services. They have significant relevance for parents in terms of how they are introduced to and supported by mental health promotion in early parenting.

MAJOR THEME	SUBTHEMES	CONCEPTS
Complexity of mental health	Defining mental health	Consternation
		Confusion
	Complexity of mental health promotion in practice	Screening
		Raising awareness
		Illness awareness
	Explaining the complexity of mental health promotion	Stigma of mental illness
		The complex scope mental health

4.3.1 Screening

Responses captured under the second subtheme of ‘Complexity of mental health promotion definitions in practice’ were grouped under a common concept of ‘screening’. This title of this concept reflects those responses that framed mental health or mental health promotion as screening using the Edinburgh Postnatal Depression Scale (EPDS) or the family assessment (child health nurses)/psychosocial (midwives) tools. The EPDS (Cox et al. 1987) is used by a number of health professionals within the perinatal period to screen parents for perinatal depression. The family assessment tool (child health nurses) and psychosocial assessment tool

(midwives) are used to gain broad information about the family during the first contact point the parent(s) has with these two services.

Midwives and child health nurses shared that this screening process was a key aspect of their role, as they could raise the issue of perinatal depression and thus discuss any issues the parent may have regarding the development of the illness or simply how they were coping with parenting. An example of this is when a child health nurse stated that mental health promotion in practice was *the PND policy around universal screening (1CHN)*. A midwife also suggested that *we've just started doing our depression and antenatal scales – so that creates another time to talk about mental health and how to have support if there are any issues with that (28M)*. In contrast, there was a number of participants whose responses included *I guess it's any information that you've given that's focused on enhancing wellbeing for a child or a mother (3CHN)* and one who saw communication as mental health promotion, *it's how you relate and how you talk and it's about just listening to the person (8CHN)*. However, the responses reflected mental health promotion as being concerned with screening tools for perinatal depression which indicated an understanding of mental health promotion in practice as predominately about depression screening.

4.3.2 Raising awareness

Other responses to this second subtheme focused on a concept titled 'raising awareness'. This term encapsulated those responses that indicated an understanding of mental health promotion as a discussion with parents around what is 'normal' for them to feel in the perinatal period and also to responses that identified resources as a way of promoting mental health if parents demonstrated a deviation to 'normal'. This area also incorporated examples of participants' practice of raising awareness. One midwife shared her thoughts of mental health promotion as raising awareness: *for our clients, for women and families to be aware of what's normal and where things deviate from normal; where they can receive help and input so they are not floundering out there (18M)*. Another midwife claimed *if everyone knows where to go for help and knows that there is help available, you don't have to put up with what you see as not normal*. She then argued that *if we can just get education on what's*

normal and people know where to go when things aren't normal. I think that's the promotion that needs to happen (15M).

In this second concept of raising awareness, participants' understanding of mental health promotion focussed on parents' feelings that were different to 'normal'. Participants then supported parents by using strategies for coping or for referral services when the parent needed/wanted to seek support. Overall, when participants said they promoted parental mental health by 'normalising' parenting feelings in the perinatal period, they intimated they were promoting mental health as similar to Jahoda's (1958) mastery over the (perinatal) environment and thus an 'ideal, positive mental health promotion' that I discussed in *Chapter Two*. However, what was evident from the data was that this normalising was actually about abnormalities and that raising awareness was actually about deviation, as opposed to encouraging how to promote existing parental capacities and strengths.

4.3.3 Perinatal depression awareness

'Perinatal depression awareness' was the final concept of this second subtheme that highlighted definitions of mental health promotion in practice. The title of this concept reflects those responses that framed mental health promotion as being about perinatal depression awareness. In these responses, raising awareness of the mental illness and its signs and symptoms was paramount and was the first response given in the majority of interviews, when asked about mental health promotion in practice. One child health nurse stated *you've always got your Beyond Blue on the TV, you see those adverts about your mental health programs*. She then verbalised how this awareness succeeded in promoting mental health, *I think, that's I guess, raising the awareness that it is out there and it can affect anybody at any time and it doesn't segregate who mental health effects (4CHN)*. Another child health nurse described that on the first visit to a parent's place *there's a blurb on post-natal depression and a pamphlet to give out. It's also in the Baby Book, talks about postnatal depression (8CHN)*. Yet another child health nurse commented about the practice of assessment and how her understanding of mental health promotion was *what's concerning them and they can feel free to bring them up, where we talk about their health and the type*

of risk factors like family violence and do they have any problems with mental illness (25CHN).

In contrast to illness awareness, one midwife commented about inclusion of the father in all discussions as a way of practising mental health promotion for the family:

the participation of the father and making him feel like he belongs and that he's not just the person who puts the garbage out. It's the three of us together...instead of being two single identities...I think that having the father involved is, for his own mental health, but for the connection with the family unit to make it grow strong – it makes a really huge difference (23M).

However, on the whole, both child health and midwifery responses related to mental illness awareness as the means by which mental health promotion is discussed with parents when in contact with the two services. This reliance on an illness understanding is not aligned with supporting a “capacity that already exists” (Pollett 2007, p.1) nor one that engages with a strengths-based focus.

4.3.4 Discussion

In this discussion section of the second subtheme ‘The complexity of mental health promotion definitions in practice’ I will be reviewing the literature that supports or refutes the concepts of screening, raising awareness and perinatal depression awareness in midwifery and child health nursing practice.

The first concept within this second subtheme, was screening, and specifically, screening for perinatal depression using the EPDS tool. Significantly, screening for perinatal depression was mentioned by most participants as their core understanding of mental health promotion. This emphasis on a tool of early detection arguably signifies an over-familiarisation with mental health promotion as being about the early detection of perinatal depression.

Screening for perinatal depression in Australia was introduced due to a growing awareness that the emotional health of parents needed to be acknowledged in a systematic fashion (Beyondblue 2008). Rates of perinatal depression have been

recognised at around 15 per cent in Australian since the 1990s (AIHW 2012) and interest in Cox et al.'s (1987) Edinburgh Postnatal Depression Scale (EPDS), a simple, quick self-report questionnaire, from around this time saw small trials of this screening tool initiated in small pockets throughout Australia and for perinatal depression soon after. The EPDS was developed initially to screen for postnatal depression in the primary care setting (Cox et al. 1987) and although it appears simple to use, training health professionals in administering and scoring the scale, giving women appropriate feedback, and understanding its limitations are important (Cox 1994).

In 2002, Beyondblue (an Australian, not-for-profit organisation for support with mental illness) began a four year trial of routine screening for perinatal depression throughout Australia, using the EPDS. Regarding the two other concepts of 'raising awareness' of deviations to the norm and perinatal depression within this study, this program also included providing information to women and their families about signs and symptoms of the illness, a form of raising awareness of signs (deviation away from the normal) and symptoms of the illness of depression. The program notably also provided education and support for primary care professionals who would be screening these parents. Therefore, it is feasible that such a dedication of resources to perinatal depression prevention could have focused midwives' and child health nurses' understandings of mental health to be about perinatal depression. Furthermore, as a consequence of these resources, understandings of prevention may also have been concluded by midwives and child health nurses in this study to be about promotion.

After the four year Beyondblue program came to an end in Australia, in 2006, there was some debate from Armstrong & Small (2007) that routine screening may not be the most effective way to identify perinatal depression. The programme was perceived as not evaluating how readily women participated in routine screening, whether they took up referrals for treatment or if routine screening improved outcomes for women. This debate in particular raised 'training' of health professionals as an issue and highlighted that further explanation was needed of how training and support were provided and how adequate pathways to care were substantiated (Armstrong & Small 2007, p.287). However, the adoption of national

screening continued after this program ended, with the development of the National Perinatal Depression Plan (NPDP) in 2008, instituting routine screening for depression during pregnancy and a follow-up check at two months after birth. Again, as with the initial Beyondblue program, follow-up support and care for women who were assessed to be at risk of or experiencing depression was advised together with in-servicing (in-house education) for health professionals to help them screen and assess expectant and new parents for depression.

Soon after this rollout more disquiet about screening appeared and there was a caution by some Australian researchers (Yelland et al. 2009) for a stronger, screening evidence-base to inform the implementation of the perinatal depression initiative. Reasons for this evidence-base caution are beyond the scope of this study. However, what is of note, is this caution about screening gave rise to ‘adjunct’ tools such as psychosocial assessments that looked at stressors within a parent’s experiences, thus allowing for a greater understanding of how a parent is coping with parenthood than perinatal depression screening alone (Price & Masho 2013). Both midwifery and child health nursing services use their own form of family assessment/psychosocial screening to investigate if parents have any risk factors for depression. Thus, adjunct tools now form the part of parental assessment by midwives and child health nurses in Tasmania (discussed in detail in the next chapter).

Significantly, Beyondblue’s perinatal clinical guidelines (Beyondblue n.d.a), developed from the initial four year program, became the default guidelines for agencies, in particular the protocols and policies examined in this study, to direct the delivery of care. These guidelines (Beyondblue) continue to form the basis of the latest representation: the National Perinatal Depression Initiative (NPDI – seen as developing from the 2008 working document) for all clinicians working with parents within the perinatal period throughout Australia. Adoption of the routine screening (under the NPDI) presently exists throughout the midwifery and child health services in Tasmania for all parents, although Tasmanian midwives had only recently been trained to use the screening tool at the time of data collection for this study (2012) and there were concerns about the availability of referral processes. The NPDI is one of two initiatives (the other is Kids in Mind – for children whose parents have a mental illness) that the DHHS currently use to “to build the foundations of mental

health and wellbeing within Tasmania” in the perinatal period (DHHS 2009, p.1), two initiatives whose focus is the early detection and prevention of mental illness, not promotion.

In short, it is significant to extrapolate that with such intense concentration on screening, training in how to use the EPDS tool, and education around raising awareness of perinatal depression, both midwives and child health nurses in this study would have been immersed in understandings of screening, raising awareness of deviations and mental illness in practice. It could also be argued that with such a concerted nationwide effort to detect and treat perinatal depression, midwives and child health nurses have become perplexed in their understandings of mental health and mental health promotion terminology in practice.

One final point regarding this second subtheme ‘Complexity of mental health in practice’, is the way participants raised awareness of deviations from ‘what is normal’, and awareness of perinatal depression. This awareness-raising could be suggestive of a foundation of practice of mental health literacy embedded within the NPDI. Jorm (2012) discusses mental health literacy as having many components: (a) knowledge of how to prevent mental disorders, (b) recognition of when a disorder is developing, (c) knowledge of help-seeking options and treatments available, (d) knowledge of effective self-help strategies for milder problems, and (e) first aid skills to support others who are developing a mental disorder or are in a mental health crisis (p.231). In this way, midwives and child health nurses not only had the knowledge of perinatal depression, they were “linked to the possibilities of action” (Jorm 2012, p.231) and could advise parents about the formal support structures in order to manage their illness – a form of “psychoeducation” (p.232). Certainly, the current NPDI, being the repository of guidelines regarding mental health promotion and wellbeing in the perinatal period, is in alignment with Jorm’s (2012) description and thus promotes a mental illness, ‘psychoeducational’ discourse within midwifery and child health nursing in Tasmania. It could therefore be argued that these guidelines that direct the care parents receive, offer little to them in the way of mental health promotion.

Midwives' and child health nurses' position descriptions claim that the participants work within a health promoting framework (Primary Health Care) with child health nursing particularly asserting an incorporation of a strengths-based approach. However, what is clear from the data is that an understanding of what constitutes promotion, as opposed to early detection and prevention, is lacking in a considerable number of participants' understandings of mental health promotion in practice. Therefore, it could be argued that both midwives and child health nurses have appropriated the terminology from the NPDI guidelines as they work within this framework (later discussed in *Chapter Five*) and that few, if any, other frameworks of wellbeing, such as Jahoda's (1958) ideal positive mental health with its three strategies of self-realisation, mastery and autonomy, have been introduced.

4.3.5 *Summary regarding the complexity of mental health promotion in practice*

In this second subtheme entitled 'Complexity of mental health promotion in practice', three concepts of screening, raising awareness of deviations from the norm, and raising awareness of mental illness appeared as forming the basis for the practice of mental health promotion with midwifery and child health nursing in Tasmania. There were a number of responses that highlighted an understanding of mental health promotion to indicate the process of communication with the client, about fatherhood participation, and how enhancing the wellbeing of the client supports mental health promotion in practice. However, the responses indicated an understanding of mental health promotion as screening, awareness raising of deviations to the norm, and perinatal depression awareness. This finding of the complexity of mental health promotion in practice is an important one as by illustrating that mental health promotion, as described by WHO (2001), is not utilised within the two services, the question is posed whether the construct is at all incorporated.

4.4 Explaining the complexity of mental health promotion

In this final subtheme within the first major theme of this study ‘Complex understandings of mental health’, data are presented that contribute to understandings of why midwives and child health nurses found discussing mental health and mental health promotion with parents complex. Two concepts have been identified as explaining this complexity: i) stigma of mental illness, and ii) the complex scope of mental health. These two concepts reflect the importance of understanding why midwives and child health nurses may appear infrequently to address these constructs in perinatal education. In the previous two subthemes, I highlighted participant concepts of consternation and confusion regarding the complexity of mental health and mental health promotion definitions. I also presented how this complexity was incorporated in the way participants define the practice of mental health promotion as screening and awareness raising of deviations to the norm and mental illness. In this subtheme of explaining the complexity, I draw on the data that attest why stigma possibly contributes to this complexity of definitions, coupled with participant responses regarding their interpretation of how complex the construct is to use with parents. In discussing these concepts, participant understandings of the role of stigma and the complex field of mental health promotion are highlighted in early parenting mental health promotion.

MAJOR THEME	SUBTHEMES	CONCEPTS
Complexity of mental health	Defining mental health	Consternation
		Confusion
	Complexity of mental health promotion in practice	Screening
		Raising awareness
		Illness awareness
	Explaining the complexity of mental health promotion	Stigma of mental illness
		The complex scope mental health

4.4.1 **Stigma of mental illness**

A number of responses in the interviews related to stigma. Participants discussed this concept as a way of explaining why mental health is hard to put into simple terms or explain to parents. They also indicated that stigma was an external concept that heavily and negatively influenced their ability to discuss mental health or emotional wellbeing with parents, as if raising the possibility of anything to do with the term 'mental' or 'emotional' could immediately drive the parents into a spectre of fear that they might already have or develop perinatal depression.

One child health nurse, for example, clarified her understanding of why mental health promotion was complex when she commented *sometimes I get a bit tangled up with why we're saying mental health? Because we don't describe someone as having mental health issues and we seem to want to couch it around polite nice words (16CHN)*. Another child health nurse remarked that *mental health is the big stigma and people say "I've got a mental health problem", you know, and I think it's also that and so people don't want to talk about it (4CHN)*. In particular, the issue of stigma arose throughout one participant's interview wherein whenever she mentioned the term mental health, she followed immediately with the phrase *for want of a better word (1CHN)*, as if to impart the term dictated interpretations from which she well distanced herself.

A number of participants indicated the effect of societal changes and a greater acceptance of mental illness. One child health nurse summarised these responses by observing, *it could be a little bit stigmatising in a way, isn't it, that it's mental health*. She then explained how in more recent times *people are trying to make it socially acceptable so it's talked about a lot, so it's got a label now. And yeah, there's a lot of advertising on TV and things like that (7CHN)*. However, despite these changes and greater acceptance of mental illness, there was still acknowledgment by some participants that parents found the topic needed to be adapted in order for it to be discussed. One child health nurse encapsulated a number of responses about this 'adaption' when she stated *yes, there was a stigma. It's certainly got a lot better because now they come in and say, "I've got a bit of the post-natal" (8CHN)*. There was also a consensus by some participants, as represented in the example below, that

there was a need to be very careful when introducing mental health promotion and the need for differentiation between mental health and mental illness:

I would say we have to be careful to...we can't too quickly link the two; mental health can lead to mental, well, poor mental health can be associated with or can perhaps lead to mental illness. But mental health can be normal, you know, it's normal to talk about mental health, one's mental health. But when you talk about mental illness that's negative connotation; you immediately think the person is sick (14M)

It was, therefore, notable to consider why mental illness was being discussed when promotion of wellbeing was the aim of mental health promotion. Where were the discussions surrounding strengths, for example? How did conversations about promoting existing parental capacity become a conversation about avoiding the stigma of perinatal depression? Certainly, these data raise a question about whether participants' descriptions and experiences of parental fear of perinatal depression had indeed affected their practice. How they communicated mental health promotion to parents in the shadow of stigma is also unidentifiable.

Stigma as a reason for explaining why mental health is complex is an important finding as it raises the issue of this external concept (stigma) potentially influencing the way midwives and child health nurses deliver information to parents about mental health promotion. Furthermore, it could be argued that therapeutic closeness to parents and not wanting to hinder that partnership relationship through raising any topics to do with mental health promotion due to this stigma, may have influenced the way participants undertook antenatal appointments/postnatal shifts and clinic visits. Thus, this role of stigma is important as it has an implication for midwifery and child health nursing therapeutic engagement (discussed in detail in *Chapter Seven*).

4.4.2 The complex scope of mental health

The second concept within the final subtheme of 'Explaining the complexity of mental health promotion definitions', highlights why mental health is so complex that it possibly makes it untenable: *It's too complex...[laughing] ...It's too complex*

(3CHN.) One midwife remarked upon the large scope of the study when she commented *what you're doing is so big...looking at what is mental health, you know (10M).*

Furthermore, one participant commented that *we have data stuff that we have to tick off and one of the things is mental health and I find I put a ton of stuff under that (8CHN)*, perhaps implying that the 'box' may not be big enough to cope with the enormity of the area nor that it is comprehensible enough to be divided into smaller boxes. Finally, this child health nurse's explanation, below, encapsulated a number of participant responses pertaining to their understandings of mental health and mental health promotion:

(groans)...well...mmmm (breathing out in a long sigh) – yeah, well mental health, look, it encompasses everything, to me mental health is not just mental. It is physical, it's psychological, it's the whole gamut because without the crux of having good physical, psychological health your mental health's not going to work either. So for me just putting it in context of mental health, it doesn't work because you've got to look at what's... if you're looking at a person, what's happening for them. So what living environment are they in, what stresses are they under, what financial things have they got going on. So all that will impact on mental health, so if you put it in, okay you've got a mental health client, well sorry, you've got everything else too (1CHN)

From the data, it appears that when some participants broke down the constructs of mental health and mental health promotion into risk determinants, it made understanding the two easier. However, they described that there were many determinants to work with, as the above participant described 'you've got everything else too', and articulating them was difficult, as was structuring them into a framework that helped them to describe what mental health was. This finding about why mental health is so complex – because the participants considered it to be so all encompassing, even overwhelming – is an important one as it has implications for practice. If midwives or child health nurses find it difficult to articulate to parents what mental health is, then promoting it will be potentially impossible.

4.4.3 Discussion

In this discussion section of the third subtheme ‘Explaining the complexity of mental health promotion’ I will be reviewing the literature that supports or refutes the concepts of stigma and the complex scope of mental health.

Goffman’s seminal works (1963;1990) on stigma describe the debilitating effects on the individual, and in particular, express his view of mental illness as being one of the most discrediting and social damaging of all stigmas. There is little evidence to date that investigates how midwives and child health nurses acknowledge stigma and mental illness in their practice. Certainly, there is some recognition that talking about and confronting the issue of mental illness during the perinatal period still poses challenges for many Australian health professionals in areas such as low-confidence in assessment and knowledge base (Yelland et al. 2006). Another potential reason for this stigma includes society’s generalised view of motherhood as being a time of emotive, idealised happiness and that not enjoying this time is still regarded as taboo (Freund 2008). Furthermore, it could be that midwives and child health nurses regard themselves as specialist primary health care providers and in doing so have conflicting attitudes whether their role is about a specialty such as mental illness or mental health promotion (Sanders 2006) and thus whether they need to be including mental illness within their scope of practice (discussed further in *Chapter Six*).

What is clear from this study is that both public stigma and self-stigmatisation of mental illness (Michaels et al. 2012) are still present. Stigma and its associated social-cognitive processes (“cues, stereotypes, prejudice and discrimination”) can be identified as one reason that could motivate a parent to avoid the label of mental illness (Corrigan 2004, p.615). Furthermore, if midwives and child health nurses are aware of research that highlight this avoidance such as Van’s (1996) study on women’s avoidance of primary care, then it would be understandable for purposes of engaging and maintaining the parent within Tasmanian services, that this stigma – and a discussion of mental health promotion – would be eschewed.

This finding regarding stigma highlights why explaining or discussing mental health promotion with parents can be difficult. It is an important finding as it reinforces the research that signifies that stigma is still very much a lived experience for consumers

who worry about receiving quality healthcare if diagnosed with a mental illness. This finding is also about the difficulty that midwives and child health nurses identify in talking about mental health promotion. This difficulty is significant as it identifies a potential gap in midwifery and child health nursing discussions, about the stigma of perinatal depression. In particular, this lack of acknowledgment of stigma behooves a discussion of research into where stigma departs from mental illness and where mental health promotion begins.

The second concept within the final subtheme of explaining the complexity of mental health, related to a finding of mental health being a complex construct to understand. Both child health nurses and midwives alike, perceived mental health and mental health promotion to be not only complex, but overwhelming at times. It could be conjectured that these two constructs, as opposed to child health nursing anticipatory guidance on developmental milestones or midwifery breastfeeding initiation, require deeply personal reflections of personal culture and values (Battams 2009) and that this reflection takes immense effort – perhaps belonging in the ‘too hard basket’? Could the complexity make a discussion of mental health promotion ‘off limits’ for midwives and child health nurses?

Mental health promotion has been described within European public health policies (Lavikainen et al. 2000, p.38) as “vague and ambiguous, and used in a rather loose way and without clearly defining its content”. With this in mind, it is important that at all times a discussion of mental health promotion be very clear and explicit about its definition – and in this way decrease the complexity. However, literature which discusses the complexity of mental health promotion is reinforced by the finding in this study of complexity in perinatal education, as the definitions are so complex and contested (as discussed in the first subtheme of defining mental health)that midwives and child health nurses who aim to promote mental health are besieged and can be left floundering. What is more significant is that there is a dearth of research regarding *how* mental health promotion is implemented (Barry & Jenkins 2007) and thus strategies to support midwives and child health nurses in this implementation are rare. For this reason, understanding how midwives and child health nurses feel about this construct is crucial in order to forge an understanding of why or why not mental health promotion is achieved.

4.4.4 Summary of explaining the complexity of mental health promotion

In this third subtheme entitled ‘Explaining the complexity of mental health promotion’, two concepts of stigma and the complex scope of mental health highlighted why mental health promotion could be challenging to discuss with parents. Firstly, participants indicated that stigma profoundly influenced how they introduced the area of mental health or mental health promotion to parents with some suggesting that care needs to be taken in practice when linking mental illness to mental health. Secondly, the complex scope of mental health appeared to make an articulation of areas relating to mental or emotional health intimidating for many participants.

This finding about participants being overwhelmed by the complexity of mental health is an important one as it reinforces the literature that discusses *how* the constructs of mental health and mental health promotion can be overwhelming to health professionals who design policies, and to those who implement them. Furthermore, this finding touches on an aspect that is further explored in *Chapter Six – Complicit?* that is, there is a perceived urgency to consider how personal culture, values and experiences impinge on the promotion of mental health in perinatal education. In doing so, mental health promotion may have the opportunity to come out of the ‘too hard basket’ and procure some airing.

4.5 Conclusion

This chapter has established that complex understandings of mental health and mental health promotion impose a cost on mental health promotion in perinatal education in Tasmania. In particular, this first findings/discussion chapter has highlighted three subthemes: defining mental health, the complexity of mental health in practice, and explaining the complexity of mental health. The first subtheme reflected how participants experienced defining mental health in the interview; the second subtheme illustrated findings that centered on their understandings of mental health in practice. The third subtheme confirmed why mental health appeared to be complex for midwives and child health nurses. Within the subthemes were a number

of concepts that detailed these complex understandings: consternation, confusion, screening, raising awareness of perinatal depression, stigma and the complex scope of mental health promotion.

From the data within this first findings/discussion chapter of the complex understandings of mental health, what is clear is that the terms mental illness and mental health promotion hold different meanings for different people in Tasmanian midwifery and child health nursing and that, more broadly, confusion about such all-encompassing constructs is still a powerful reason for the low priority given to both mental illness and mental health promotion as reinforced by Sartorius (1990) and Hermann et al. (2001). It is significant to note that midwives and child health nurses in this study may underestimate their health promotional scope when direction is given to other areas such as psychosocial assessments with a focus more on set priorities of early detection than exploring a strengths-based framework. However, in wider terms, it could also be true that midwives and child health nurses just feel “daunted by the task” of promoting mental health (Hermann et al., 2001, p.713) in all its complexity.

Chapter 5

Findings and discussion: Default mental illness framework

The elephant in the boa constrictor.

"...In the book it said: "Boa constrictors swallow their prey whole, without chewing it. After that they are not able to move, and they sleep through the six months that they need for digestion." At the age of six, I pondered deeply, then, over the adventures of the jungle. And after some work with a coloured pencil I succeeded in making my first drawing. My drawing number 1. It looked like this:



I showed my masterpiece to the grown-ups, and asked them whether the drawing frightened them. They answered me: "Why should anyone be frightened by a hat?" My drawing was not a picture of a hat. It was a picture of a boa constrictor digesting an elephant. Then, I drew the inside of the boa constrictor, so that the grown-ups could see it clearly. They always need to have things explained."



(de Saint-Exupery 1943)

De Saint-Exupery's novel, about a small boy (the Little Prince) who lives on the asteroid B 612, is a book of philosophical contemplations and morals. I was introduced to this book in my high school French classes and have never forgotten the author's childhood illustration. One of the main themes of de Saint-Exupery's novel is that of looking beneath the surface of things and to be wary of becoming too narrow-minded.

5.1 Introduction

This chapter is the second of three findings/discussion chapters. The first chapter explored how the complex construct of mental health and its associated *terminology* impacted upon its usage by midwives and child health nurses and thus potentially on parental experience of this construct in Tasmania. This second chapter discusses the second major theme: default mental illness framework and focusses not so much on the terminology, as on the *practice protocols of mental health promotion* by the midwives and child health nurses. Two subthemes within this second major theme include: 1) participants' practice embedded within a mental illness framework, and 2) policies and protocols embedded within a mental illness framework. The first subtheme discusses participants' examples of their practices of mental health promotion. The second subtheme analyses the policies and protocols for mental health promotional content from the interviews and documents collected from within the two services. There are a number of concepts within these two subthemes and these are depicted in the table below for clarity, and are also explained within the subthemes' introductions.

MAJOR THEME	SUBTHEMES	CONCEPTS
Default mental illness framework	Participant practice embedded in a mental illness framework	Risk factors
		Health promotion without 'mental'
		Knowledge construction of mental health promotion
		Workplace structure
	Policies and protocols embedded in a mental illness framework	Anticipatory guidance
		Family/psychosocial assessments
		Edinburgh Postnatal Depression Scale (EPDS)
		Perinatal depression resources
		ObstetriX
		Child health surveillance
		Antenatal parenting classes

As this second major theme presents the data as defaulting to a framework, firstly, I need to explain that I define framework as a way of conceptualising an issue. De Saint-Exupery's framework within the Little Prince (1943) could be considered as childlike with its innocence, vulnerabilities and lack of guile. It is a position of commentary and inspiration that de Saint-Exupery repeatedly visits in his novel and we the readers are struck by our own duplicity and world-weariness in its reflection. When I say that participants' responses defaulted to a particular framework, I am expressing a finding from the analysis process whereby *when* I endeavoured to obtain responses to building "the capacity that already exists" (Pollett 2007, p.1) in practice, two thirds of the participants conceptualised mental health promotion as perinatal depression – participant responses appeared to be embedded within a mental illness framework. In short, this embedding suggests a greater need for midwives and child health nurses to look beneath the surface of the mental health promotion construct in perinatal education and, as de Saint-Exupery cautions, to be wary of the narrow representation that this construct potentially receives in both services and delivers to parents in practice.

As an introductory example, a child health nurse's comment, below, captures many participant descriptions of what both Antonovsky (1979) and Moodie (1999) express as a continuum from mental wellness and mental illness, or ease to disease:

Where does adjustment to parenthood move into an actual mental health disease or a mental health condition that needs extra support and where does normal support of a new family get you across that line without you actually becoming debilitated by it? (15 CHN)

This comment represents how many participants discussed adjustment in parenting and how adjustment then devolved to illness awareness. Data from these Tasmanian child health nurses and midwives suggest that not enough emphasis is given to promotional support within the two services under exploration in this study. Furthermore, there appears to be an accentuation of what needs extra support in indicative/selective or targeted approaches (Mrazek & Haggerty 1994) to the detriment of universal support of strengths and promoting further parent capacity within the perinatal period.

5.2 Participant practice embedded in an illness framework

"I administer them (the stars of the universe)...I count them and I recount them. It is difficult...I write the number of the stars on a little paper. And then I put this paper in a drawer and lock it with a key", said the business man.

"And that is all?" asked the Little Prince.

"That is enough", said the business man.

(de Saint-Exupery 1943)

This first subtheme presents the finding that midwives and child health nurses' practice of promoting mental health is embedded in a mental illness framework. There are four concepts in this subtheme: i) risk factors, ii) (mental) health promotion, iii) knowledge construction, and iv) workplace structure.

As previously outlined in *Chapter Three - Methodology*, my research question asked "what do midwives and child health nurses consider 'creates mental health' in the perinatal period?" In order to answer this question, I asked a number of interview questions, both broad and focussed, that related to understandings and implementations of mental health promotion within participants' practice. The following findings within this first subtheme of 'participant practice being embedded in a mental illness framework' suggest an inability to remain within a wellness paradigm even when the interview questions were deliberately structured within one. In many circumstances an illness orientation to mental health promotion '*was enough*' (de Saint-Exupery 1943).

MAJOR THEME	SUBTHEMES	CONCEPTS
Default mental illness framework	Participant practice embedded in a mental illness framework	Risk factors
		Health promotion without 'mental'
		Knowledge construction of mental health promotion
		Workplace structure
	Policies and protocols embedded in a mental illness framework	Anticipatory guidance
		Family/psychosocial assessments
		Edinburgh Postnatal Depression Scale (EPDS)
		Perinatal depression resources
		ObstetriX
		Child health surveillance
		Antenatal parenting classes

5.2.1 Risk factors

This concept highlights those factors that place a person at risk of developing a disease. There were numerous responses both by midwives and child health nurses describing risk factors as mental health promotion throughout the interviews, as opposed to protective factors or examples of traits from a strengths-based framework. One participant discussed *anything that lowers your ability to cope...lack of sleep, lack of supportive partner (5CHN)*. Another participant encapsulated the flow of many of the participants' replies to a number of questions about mental health and mental health promotion and began with a claim that *Oh! There are lots of things (12CHN)* when asked about mental health or mental wellness. However, as she began to describe her child health practice, she defaulted to a description of risk factors for illness such as things in their past...*difficult relationships with their mother* which she described as therefore making it more likely to include *poor*

mental health outcomes...family violence or step parenting issues...financial problems, lack of family or support networks...they could have a past history of mental illness (12CHN).

In contrast, a number of child health nurses highlighted having a supportive network or having a supportive partner as being ways to promote wellbeing. However, on the whole, an emphasis on risk factors continued even when asked about the building of wellbeing in the parenting field: *we are living in an era where breakdown is huge...you start a downhill slider (23CHN).* In short, risk factors were identified as mental health promotion by the participants with only a few including informal or formal support structures as promoting wellbeing.

5.2.2 (Mental) health promotion

This concept relates to the construct of health promotion and how it was viewed with a positive connotation before the word ‘mental’ was placed in front of ‘health promotion’. In some interviews, participants espoused positive examples in practice of promoting parental health through health education. However, when asked about mental health promotion, participants defaulted to examples that focused upon mental illness.

When health promotion, as opposed to *mental* health promotion, was discussed in the interviews, the concept was described by some participants as *taking the opportunity at all times to promote parenting practices or self-care practices that work towards good health outcomes for the future.* In particular, this participant depicted such activities as *joining in a new parent group or the pram walking group, or a play group* to be health promoting. She discussed how parents feed their babies: *we’ll talk about the best options to do that sort of thing (CHN1)* to outline how health promotion in infant nutrition is achieved. However, during the interview, when I placed the word ‘mental’ or ‘wellbeing’ in front of the term health promotion, an illness orientation was supported by the participants with one participant sharing her mental health promotional strategies in parenting education classes as *I specifically do a card game around postnatal depression and look at what are the symptoms (15CHN).*

5.2.3 Knowledge construction of mental health promotion

The concept of knowledge construction relates to data regarding a default to an illness framework in the little researched area of midwives and child health nurses' constructions of practice in mental health promotion. There were two forms of knowledge distinguishable from participant constructions of mental health promotion: i) professional education and development, and ii) personal and familial experience.

Many participants were unable to stay within a wellness orientation when I asked them about their knowledge construction of mental health promotion and how it helped them to promote mental health in practice. More than half of the responses noted mental illness awareness or training in mental illnesses as contributing to their understanding: *at Uni, when I did the post grad for child health...we had a number of study days and things through child health about doing Edinburgh and then we also did the Edinburgh postnatal depression questionnaire (12CHN)*. Another participant clarified her construction of wellbeing by outlining *when I did my paediatrics, I did a stint in the hospital's psychiatric ward and we've done some study days on postnatal depression (28M)*. In another example, after being reminded of her description of mental health promotion as supporting parents *to live their lives well*, one midwife described further where she obtained this knowledge, by defaulting to an example of learning from a colleague who *said to me that most of the postnatal depression she'd seen was related to people's circumstances...* (7M).

5.2.4 Workplace structure

This final concept within the first subtheme of 'participant practice embedded within a mental illness framework' focusses on workplace structure and, in particular, how the structure was understood to be about mental illness, as opposed to mental health promotion.

A number of participants, mostly midwives, expressed issues with their workplace, stating they thought their workplace did not support mental health promotion. For example, one midwife portrayed her workplace structure as needing greater emphasis on promoting mental health in parents. When asked how this could happen, her

response was *we desperately need to have a mental health nurse. When asked how this would help her to promote mental health in parents, she replied we can refer them to a person who has the time to sit down with them and really talk about the issues, 'cause we aren't mental health trained (28M).*

Another example of workplace structure involved a participant indicating that annual mandatory training about mental health promotion (similar to basic life skills or manual handling) would be ideal and when asked what that would look like, she responded *we are doing the EPDS...so, that would give us a heads up on a lot of things (18M).* Her reply indicated that EPDS training on yearly basis, and the content within, could support an annual updating of mental health promotional information. In contrast, one child health nurse saw the issue of autonomy in her workplace as promoting mental health in parents as she was able to work around timeframes to ensure that she could *work at the grassroots in the community setting and be involved part in community activities (1CHN).* However, the responses described mental illness in workplace structures as indicative of mental health promotion practice.

The first example within this concept of workplace structure depicted how the employment of a mental health nurse would support mental health promotion in the workplace. However, a mental health nurse's role in this capacity would be to support those who have been detected at risk of or suffering from perinatal depression. The second example related to hospital practices of mandatory training and highlighted how a participant, when asked about mental health promotion in practice, translated annual mental health promotion updates to be about perinatal depression screening in servicing. Again, mental illness was at the forefront of both participants' examples. Furthermore, in the second example of mandatory training, the placement of perinatal depression screening as a core component of compulsory in servicing would ensure that workplace structures about mental health promotion incorporate an illness orientation. These types of embedded practices subtly influence how midwives and child health nurses carry out their work. Embedding these two hypothetical examples of employing a mental health nurse and annual mandatory training on perinatal depression could potentially ensure a diminished promotional voice in the workplace and thus a diminished opportunity for parents.

5.2.5 Discussion

When participants described how they promoted wellbeing in practice, they focussed on risk factors contributing to the development of mental illness. This risk factor focus raises the issue of a default in terminology that aims to detect signs or early warning indicators of mental illness development. In placing an emphasis on risk awareness or identification as the way to promote mental health, the participants were following trends in policy and literature to include epidemiological markers regarding mental health promotion that seek to target risk and assess vulnerability in parents for mental illness development (Mittelmark 2005; Barry & Jenkins 2007). There is a plethora of risk identification literature within mental health promotion as noted by Henderson (2007), and in particular within perinatal depression development (see examples within the National (Australian) Health and Medical Research Council (NHMRC) 2008). Existing mental health literature predominantly reflects a prevention model in relating risk factors to universal, indicative and selective interventions (Mrazek & Haggerty 1994; Hermann 2001). As such, the participants' responses reinforced what is presented in the literature on mental health promotion with only a number of child health nurses discussing strengths-based examples. Both child health nurses and midwives are acknowledged in policy documents (DHHS 2011) as working within a Primary Health Care framework and yet in this study there was little departure from a risk factor-oriented population health, or targeted Selective Primary Health Care (Werner 1984) mechanisms of mental illness.

This emphasis on risk factors by midwives and child health nursing when discussing mental health promotion is noteworthy as it signifies how midwives and child health nurses implement the practice of mental health promotion with parents. This finding of risk-orientation has consequences for perinatal education as it indicates there is an emphasis on risk awareness and early detection of perinatal depression and that there needs to be a greater understanding and acknowledgement from midwives and child health nurses of both protective factors (albeit part of a risk-based framework) and a promotion of the strengths parents already bring to early parenting.

As highlighted in *Chapter Two – Literature Review*, health promotion is a term that is contested, both in health professions and outside of them, with nurses being unsure about how to implement it (Whitehead 2009). The participants in this study shared examples of physical exercise and good nutrition as ways of promoting health in parents. These examples reinforce what is known about health promotion, where it is perceived to be about modifying behaviours in activities such as eating and exercise (Buchanan 2006) and which is aligned to health education and the development of personal skills (WHO CPHA 1986). This discussion of health education as opposed to health promotion is not an unknown phenomenon with the two frequently being used interchangeably in nursing (Norton 1998, Gonser & McGuiness 2001, Whitehead 2001, Cross 2005, Rush et al. 2005, Casey 2007, Irvine 2007) with little differentiation between the two described (Whitehead 2008). Furthermore, given that there are very few practical examples of what constitutes health promotion activity and how it should be applied in practice (Caelli et al. 2003), it is unsurprising that midwives and child health nurses described health education as health promotion.

However, there was something more significant about the responses that indicated health promotion was about being connected to other parents, to being part of play groups or to the parent practising self-care and learning to say ‘no’ when too busy. These responses were also in contrast to (mental) health education programs that are “effective in getting people to adopt predetermined health behaviours, irrespective of whether such programs help people to gain insight into their own motivations” (Buchanan 2006, p.2723) and thus leave little room for mastery over one’s environment. These participants’ data about being connected to other parents, to play groups and to self-care actually described mental health promotion as it incorporated concepts of social cohesion and self-efficacy, and promoted parental wellbeing through strengths-based interventions (Jahoda 1958; DeFrain & Asay 2007). However, these participants who described these aspects of mental health promotion did not recognise their responses as mental health promotion and this could be explained if they were of the opinion that health and mental health were one and the same, as indeed some were. However, when the practice of mental health promotion or promotion of wellbeing (as opposed to health promotion) was discussed with these same participants, there was an immediate default to mental illness when describing their practice.

This tendency to illness in midwifery and child health nursing practice is an important finding as it pertains to midwifery and child health nursing clarity of how they practice mental health promotion in their roles. Furthermore, if midwives and child health nurses are the most logical people to support parents with health literacy (McMurray 2007), in itself a major part of health promotion, then clarity is important as is “raising the salience of positive connotations to mental health” to support public perceptions of the construct (Donovan et al. 2007, p.8). What is significant is that many participants didn’t recognise a difference between health promotion (ostensibly health education in primary care practice) and mental health promotion. This blurring of constructs (health promotion and mental health promotion) by midwives and child health nurses in practice could also impact upon which components of health promotion and mental health promotion midwives and child health nurses discuss with parents and in which way.

Does the distinction between health promotion and mental health promotion in midwives’ and child health nurses’ practice matter? I argue that it does have important consequences for reasons of emphasis. There appears to be an understanding within some participants that emphasising the mental health promotional concepts such as self-actualisation, gaining mastery over a person’s environment or individual autonomy that Jahoda (1958) expounds, has merit. However, some midwives and child health nurses in this study viewed these concepts as health promotion and not as mental health promotion. One could argue that where participants acknowledged a holistic view of health (the dualism of health and mental health is negated) their interactions with parents will contain only health promotional concepts such as listed by Jahoda, as they perceive them as one and the same.

Yet, health promotion and mental health promotion are terms that are *embedded* in midwifery and child health nursing practices through assessment tools and policies and are used interchangeably; they are not acknowledged as one and the same. Therefore, the findings from this study reinforce literature that contends this distinction between the two is not clear in practice. The implication of these findings indicate that there is a question mark around what is being discussed in midwifery and child health nursing, and possibly, more significantly, what is being omitted.

In each of the two areas of knowledge construction of mental health promotion i) professional education and development and ii) personal and familial experience, participants maintained their constructions as being based on depression awareness. Many cited university education as providing information on perinatal depression, and professional development through the workplace around the EPDS. A third of participants also acknowledged that having family or friends with a mental illness had impacted upon how they subsequently supported parents with a mental illness in practice.

Professional education and development is well represented in literature and includes how nursing knowledge is constructed (Carper 1978; Benner 1984; Paley et al. 2007). In particular, knowledge crafted from professional education is noted as knowledge from research evidence. Knowledge constructed from working in the role of midwife or child health nurse is described as knowledge from clinical experience, “or affirmed experience” (Stetler et al. 1998, p.47) and incorporates how midwives and child health nurses craft their practice from working in partnership with parents (Rycroft-Malone et al. 2004). However, it is also significant to note that many participants spoke about their personal experiences of mental illness as influencing their understanding of mental health and mental health promotion, suggestive of a form of tacit knowledge (Polanyi 1958) that contributes to their practice.

This finding regarding the two ways many participants constructed their knowledge of mental health promotion is significant for two reasons: firstly, it reveals how midwives and child health nurses construct their understanding of mental health promotion and thus how this construction potentially impacts upon their practice and, in turn, parents. Secondly, it could also be argued that this finding uncovers how their understanding of mental health promotion is influenced by their interpretation of the concept and by the information around them from which they construct their knowledge of mental health promotion: university education, professional in-servicing, working with parents and finally their own personal experiences outside of the work context. This finding regarding how the participants constructed their knowledge of mental health promotion advocates a discussion with university providers of midwifery and child health nursing, and with in-servicing educators and

curriculum developers of the two services, to incorporate mental health promotional content as opposed to mental illness awareness.

The finding that participant understandings of workplace structures are embedded in a mental illness framework can be viewed in three ways. Firstly, there was a perception of mental health promotion in practice as a need to counsel parents who are unwell mentally. Secondly, the roles of midwives and child health nurses did not allow adequate time to talk to parents about these issues (hence the need for another midwife/nurse to do so) and, thus arguably more importantly, that talking about mental illness with parents requires time. Thirdly, midwives, and potentially child health nurses, commented that they were not trained in mental health, which I interpreted to mean not educated in mental illnesses such as depression and bi-polar affective disorders.

There are few studies that discuss midwifery and child health nursing as including counselling, having time to counsel, or receiving detailed education regarding mental illnesses (as opposed to a brief description of the different illnesses). Certainly, both services in Tasmania, the site of this study, provide anticipatory guidance and this concept is acknowledged in their workplace practices. However, the initial midwife's example in this subtheme alluded to counselling parents when they had been identified with an illness indicator (such as high EPDS score) and not to anticipatory guidance. Since the provision of the National (Australian) Perinatal Depression Initiative (NPDI), there have been a small number of studies that have examined how midwives implement the EPDS and manage supporting a parent with 'psychosocial' issues and perinatal depression. These Australian studies include an evaluation of an program (ANEW) that supports midwives to engage with parents with psychosocial issues (Gunn et al. 2006); an assessment of the promotion of parental psychosocial health (Yelland et al. 2007); a postal survey to assess Australian midwives' attitudes towards caring for women with emotional distress and their perceptions of the extent to which workplace policies and processes hindered such care (Jones et al. 2011); and an evaluation of an advanced communication skills education package for midwives caring for women with psychosocial issues during the postnatal period (McLachlan et al. 2011). Within these studies, inadequate time is cited as a factor in not being able to support women who indicate as having psychosocial issues

(McLachlan et al. 2011), as is little formal education in managing these parents for midwives (Gunn et al. 2006). A lack of adequate education being undertaken with midwives is still a concern and one this study's findings reinforce.

In short, this concept of workplace practices indicated that autonomy (Buchanan 2006) within workplace structure was of value when promoting mental health. However, what is noteworthy is that participants indicated that mental health promotion in the workplace structure pertained to mental illness support and education. The acknowledgement of mental health promotion as interaction and engagement with community (child health) or about opportunities in midwifery-led education classes was rare in child health nurses' responses and discussed by only one midwife.

That workplace structure was rarely perceived in terms of mental health promotion, as opposed to prevention of mental illness, is a significant finding. Greater detail around why this may be the case is offered in *Chapter Seven*. However, the evidence of this workplace structure concept denotes how midwives' and child health nurses' descriptions of mental health promotion practices directly defer to mental illness prevention or treatment (counselling). The major implication of this finding is that a misappropriation of the term mental health promotion to mental illness has an impact on how workplaces structures are developed in the first place and then implemented. Without a clear recognition of how workplace structures are developed to support mental health promotion, the construct has the potential to be lost in midwifery and child health nursing services and consequently lost to the parents.

5.2.6 *Summary of being embedded within a mental illness framework*

The theme of this second findings/discussion chapter is a default mental illness framework. This first subtheme within this chapter discussed how participants' descriptions of their practice of mental health promotion were embedded within an illness framework through an examination of four concepts: risk factors, (mental) health promotion, knowledge construction, and workplace structure.

The business man who lives on his own planet and counts all the stars in the Little Prince's galaxy has an important job (de Saint-Exupery 1943). However, the Little Prince sees the business man's job as futile – not because he counts the stars over and over but because the business man says that he owns the stars that he counts. The Little Prince indignantly tells him that he owns a flower and three volcanoes but that he waters and tends to the flower and cleans out the volcanoes and in doing so is of use to them. He concludes that counting and owning the stars does not make the business man valuable to the stars and argues that being of use is far more important.

I, too, question whether performing tasks is of value, unless they are of use to someone and thus of worth to him/her or to others? What is the point of such terms as mental wellbeing, positive mental health, mentally healthy, and mental health promotion if they are not understood, or if understood, untranslatable to parents? Where do the hopes and the anticipation of each attendee from every health promotion conference, since the inaugural 1986 development of the Ottawa Charter, live on in mental health promotion? Keyes (2007) proclaims that mental health promotion's time has come and yet it does not seem to be represented in midwifery and child health nursing in this study where risk factors hold a greater focus than strengths, where health promotion is embraced in a salutary education model but mental health promotion attracts an illness connotation, where knowledge construction embodies illness experience and education, and where workplace structure defaults to an early detection and prevention orientation.

5.3 Policies and protocols embedded in mental illness framework

*"If your only tool is a hammer,
then all your problems will be nails."*

(Maslow 1966)

In this second findings/discussion chapter that proposes a default mental illness framework, the first subtheme presented findings relating to participants' descriptions of mental health promotional practice being embedded within an illness framework. This second subtheme presents a finding of mental illness being

embedded within the policies, protocols and tools that the participants described they utilised for mental health promotion. In particular, this subtheme firstly illustrates this illness-orientation in practice by analysing participant interview responses which raised five practice concepts as being part of mental health promotion practice. Secondly, this subtheme presents an analysis of the documents used in practice (the second form of data for this study) of these five concepts. Thirdly, there is an additional document analysis of mental health promotion within parenting education class curricula. For purposes of clarity within this subtheme, any words pertaining to the documents used as examples are italicised.

In short, this second subtheme discusses how the tools, policies and protocols employed by child health nurses and midwives do or do not incorporate mental health promotion for parents. The question of why this is or isn't so is addressed in Chapter Six. In this second subtheme there are seven concepts regarding practice: i) anticipatory guidance, ii) family/psychosocial assessments, iii) EPDS iv) perinatal depression resources, v) ObstetriX (midwifery database), vi) child health surveillance, and vii) antenatal parenting classes.

MAJOR THEME	SUBTHEMES	CONCEPTS
Default mental illness framework	Participant practice embedded in a mental illness framework	Risk factors
		Health promotion without 'mental'
		Knowledge construction of mental health promotion
		Workplace structure
	Policies and protocols embedded in a mental illness framework	Anticipatory guidance
		Family/psychosocial assessments
		Edinburgh Postnatal Depression Scale (EPDS)
		Perinatal depression resources
		ObstetriX
		Child health surveillance
		Antenatal parenting classes

5.3.1 Anticipatory guidance

The concept of anticipatory guidance within this subtheme pertains to how it was perceived to be used for mental health promotion. Given the importance of anticipatory guidance in the roles of midwifery and child health nursing, it was expected that this concept would be used by participants for the purposes of health promotion and mental health promotion. This would be particularly so in child health nursing as it is a much more explicit process than in midwifery practice. What I mean by 'explicit' is that it is understood (McMurray 1993) as more embedded in protocols and policies within child health nursing.

An example of this guidance was when one participant stated how she would *bring up the subject of mental health promotion without there actually having to be an issue as a way of anticipatory guidance*. She then went on to say that she would mention to the parent that *this kind of thing could happen and if it does, this is where*

you get help. In her final comment that *it's actually raising the issue when it's not necessarily an issue (7CHN)*, there was a clear inference that her use of anticipatory guidance indicated awareness of and support for mental illness.

Another child health nurse stated *in terms of health promotion, I think that's part of anticipatory guidance for parents, in terms of the self-care and linking them in with the social support networks around, naming up that this is something that's important (CHN16)*. When she said this, I began to consider whether her use of anticipatory guidance was perhaps boosting those mental health promotional elements of support networks, albeit formal supports. At this point, she didn't indicate if she had asked what supports the parent already had to build on and therefore I assumed she meant support as a social networking link. However, her next sentence, *you know that we don't just expect people to be out there soldiering on, with the motherhood myth (16CHN)* did imply mental illness prevention.

Within the documents collected from the two services, there was some direction regarding the topics that midwives and child health nurses discussed as anticipatory guidance, some of which could be understood to represent mental health promotion. However, under analysis, it was clear that any discussion defaulted to illness prevention rather than promotion. For example, within midwifery, the main clinical pathway is a database called ObstetriX (discussed in detail later in this chapter). Antenatally, on parent admission, the ObstetriX (DHHS 2013) database affords each midwife the ability to record a small number of areas that could be used as a form of anticipatory guidance. In content analysis for mental health promotion, the database had a box labelled '*psychosocial*', together with two words '*emotional support*'. However, what was significant was there was little direction given to midwives within the database about content and about how to direct their questioning, apart from '*is there someone to talk to about your feelings and worries?*' when the cursor highlighted the '*emotional support*' tab. In this single tab – being all that could be named as mental health promotion in the entire database – the focus of emotional support '*feelings and worries*' appears to be about illness prevention.

It was a similar situation with child health nurses when they used the protocols of family assessment, the EDPS tool, and the parent's child health book (given to

parents in hospital, on discharge, that they then keep and bring to child health clinics) that relates to child surveillance. Within these tools, there were headings that the child health nurse was able to use to guide his/her conversation with the parent (which are described in the next concepts). However, there was little guidance given to content regarding the headings and thus each child health nurse discussed his/her own interpretation from his/her knowledge construction regarding these areas.

5.3.2 Family/psychosocial assessment

This concept within the subtheme ‘policies and protocols embedded in a mental illness framework’, relates to the interview data that described the family and psychosocial assessment as being part of the process of promoting mental health. Midwives perform the psychosocial assessment (using ObstetriX) in antenatal care initially, whilst child health nurses use the family assessment tool with parents in their clinics during their scheduled appointments or on home visits. Postnatally, midwives follow a clinical pathway (hard copy as opposed to computer database record) until the parent is discharged from their care. In this section, two examples from a number of responses regarding these assessments are representative of how the participants perceived these tools supported mental health promotion.

One child health nurse stated initially that *when we go and finish off our visit, we do a little wellbeing thing, we actually dig, saying that this is a family assessment we use and it actually has specific topics (CHN4)*. She then went on to describe how the tool supported her with mental health promotion: *so one (of these topics) is mental health and you say “this one’s just asking about mental health, have you had any concerns”? From her response, it was apparent that she saw the heading of mental health as pertaining to illness then if they have had depression before, I’d say, “okay chance of getting postnatal depression is...” (4CHN)*. She went on to say that this would make them aware that perinatal depression can reoccur in subsequent pregnancies and in the postnatal period. She finished by saying that *if they’d had nothing I’d say, “okay, quite commonly some mums can get a bit of postnatal depression down the track, it’s normal, people are there to support you” (4CHN)*.

This next example highlights a midwife's experience of assessing for psychosocial or emotional health. Initially she stated that *there are no tools to help practicing midwives to conduct, or to be more accurate in their assessment(14M)*. She was concerned that midwives had little direction in understanding the form: *there is an item on the pathway that says, "psychosocial support"; what does it mean?* She further explained that there were no definitions or instructions: *it's very much an in-house document, so you sort of develop your own understanding of that*. She then described her understanding of psychosocial support from her own reading, but went on to say she was somewhat apprehensive that her understanding of what it is, *may be different to the next midwife working with me (14M)* and thus how there could be inconsistencies for parents.

In brief, both child health nursing and midwifery participants perceived mental health promotion as taking place when they performed the state-wide, DHHS psychosocial (midwives) and family assessments (child health nurses) respectively. However, a key finding of illness orientation within the practice of family and psychosocial assessment from the interview data requires an understanding of how participants incorporated this orientation.

In the first example above, the child health nurse discussed the family assessment as being about mental health and continued on with an illness-orientated question to the parent. This illness orientation could have been influenced by the content within the family assessment as during the process of content analysis of this document (second form of data collected) the section headed '*mental health*' needed investigation.

Each section's heading within the child health nursing family assessment form (CHAPS 2011) has a subtext written for the child health nurse as an opening statement to introduce the section to the parent. This is then followed by a number of open-ended questions. The subtext of the '*Mental health*' section states that '*most parents feel emotionally different following the birth of their baby*'. This subtext is then followed by questions that could indicate why the child health nurse devolved to illness when using this family assessment tool:

- *What, if any, mental health **problems** have you experienced?*
- *If you have a mental health **problem**, what care do you receive?*

- *What has been your experience in regard to **postnatal depression** after the birth of a previous child?*
- *How worried are you that you might experience **postnatal depression** with this baby?*
- *Does your partner have any mental health **problems**, if so, what care does your partner receive?*

(DHHS 2011) bold font emphasis mine

The section 'mental health' clearly relates to mental illness with its preponderance of terminology relating to mental health problems and postnatal depression.

There are thirteen other sections on the family assessment tool that child health nurses discussed with parents including social support, financial management, housing and living environment, relationship with baby/children, and parenting skills, (together with child abuse, interpersonal violence, medical conditions, intellectual capacity and substance abuse). The family assessment form describes these sections as aimed at supporting a strengths-based approach in its content. However, although there is some evidence of strength's-based terminology, the majority of the form is representative more of screening for risk.

The 'Social Support' section commences with the subtext: '*Many families have few supports these days, because of their lifestyle or the distance from their families*' and then continued on with the following questions that child health nurses could choose to ask, where appropriate:

- *Who do you receive your support from?*
- *How long have you lived in the area?*
- *What family or friends could help you if you needed it?*
- *In what way are family and friends helping you?*
- *If you had a problem with the baby, whom would you ask for help?*
- *What events have happened in the last year that has placed a **strain** on you or your family?*

These questions suggest a less risk-focussed line of inquiry in most of this section, as do those within the section entitled 'Housing and Living Environment'. However, there still exists a pervasion of deficit terminology in both:

There are all sorts of housing arrangements that people find themselves in:

- *How is your housing situation working out for you?*

- *What housing concerns do you have?*
- *What are your housing plans for the longer term?*
- *How many times have you moved in the last couple years?*

The arrival of a new baby can disrupt existing routines:

- *How are you managing to care for your baby and keeping up with your household chores?*
- *How are you finding the juggle of caring for your baby and managing your other responsibilities?*

The section ‘Financial management’ returned to a mainly risk narrative in its questions:

- *How are decisions made around finances in your family?*
- *Many families find it difficult to make ends meet; how is it for your family?*
- *If any, what financial concerns do you have?*
- *How difficult is it for you to manage financially?*
- *How worried are you about having enough money to make ends meet?*
- *If you were **short of money**, who could you ask to help you out?*

The sections (CHAPS 2011, pp. 3-5) regarding relationships with baby/children and parenting skills were suggestive of greater strengths-based terminology:

Healthy relationships in the early years builds resilience in children and stronger families:

- *How do you and your partner parent together?*
- *How do you (either of you) feel about being a new mum (dad)?*
- *How do you (either of you) feel about having your baby at home?*
- *What did you think being a parent would be like?*
- *What concerns (if any) do you have about your child’s behaviour?*

*Raising children is a **big job**:*

- *How are you or your partner going caring for and looking after your baby?*
- *Many parents raise their children the same way they were brought up themselves, what ideas/plans do you have to raise your baby?*
- *What did you (your partner) like and dislike about how you were parented? What would you do differently?*
- *What plan do you have for raising your own child? What help do you need (if any) to change how you will parent your child?*

One example from the interview data presented a midwife’s concern about a lack of guidance for assessing parents for psychosocial support. On the midwifery clinical pathway (DHHS 2009) for postnatal care (hard copy) there is, as she stated, a

criterion, titled '*psychosocial*' but it has no guiding words. This is in contrast to '*activity level and hygiene*' which has some guiding words for midwives to consider whether the parent is '*independent mobility/self-caring*'. Another criterion is '*nutrition*' and directs the midwife to '*encourage high fibre/protein*'. Even '*pain management*' has '*as charted*' next to it, as a suggestion. There was little indication either in the interview data or in these two assessment tools (document analysis) that mental health promotion occurred from the beginning of a parent's interaction with midwives in the antenatal period to discharge postnatally.

5.3.3 *Edinburgh Postnatal Depression Scale (EPDS) screening*

This concept within the subtheme 'policies and protocols embedded in a mental illness framework' relates to how midwives and child health nurses described the EPDS as being part of the process of promoting mental health. The EPDS screening is one example of an overlap in this study, mentioned at the end of *Chapter Three – Methodology*, where a concept can exist in two chapters. In *Chapter Four – 'Much ado about nothing?'*, participants 'defined' mental health promotion as 'screening'. In this chapter, the EPDS was highlighted as part of the process of mental health promotion. The interview data suggest that participants considered that the *use* of the EDPS in both services legitimised discussion regarding mental health promotion, and that it formed a springboard to many conversations around how the parent was adapting to parenthood. One midwife's response, in particular, summarised how many participants interpreted the EPDS in practice:

So, the Edinburgh postnatal depression screening tool, international researched based screening tool and basically, is a health promotion strategy to screen all women universally – to screen and not diagnose, but screen for stresses during pregnancy that could cause anxiety and could increase depression throughout pregnancy and particularly could be linked to postnatal effect, how the woman is feeling, how the family is feeling postnatally (22M)

There were a number of other responses that indicated the EDPS helped to normalise mental health promotion. One participant stated that *I think (it's) really helpful as it helps to normalise it with people*. I asked her what she meant by normalise and she repeated a conversation that she said she often had with parents "*Here's the thing we*

usually do at eight weeks. Happy to do that? Good, here's the pen, now fill it in" (7CHN). However, it was clear from examples of this and similar responses that the EPDS helped to normalise screening for perinatal depression and not for mental health promotion.

Some participants indicated how the EPDS helped them to ascertain more information about how the parent was adapting to parenthood, that the EPDS wasn't *just a 'tick box'* and that *I've done the Edinburgh, yep* or that *I'll just file that in her history without actually looking at it* (15M). This participant specified that she would ask the parent *can we just touch base on this for a minute as you've ticked this box here. What were you thinking about when you ticked that box on that bit of paper?* Furthermore, she would ask *is there something we can help you with to bring that (meaning EPDS score) up a bit?* (15M). Another participant acknowledged that the new process of including the EPDS in her practice *creates another time to talk about mental health and how to have support if there are any issues with that* (28M). Finally, one participant stated that *the Edinburgh depression scale that we are introducing will be forcing us to at least address something* (19M).

Two responses indicated that specifically lifting information from the parent's EPDS results and then discussing it supported mental health promotion. Firstly one child health nurse stated that *we talk to mothers too from the EPDS, that sometimes if the mothers can actually take some time out and do something for themselves it helps them not to get depressed* (9CHN) thus indicating that behaviour modification can support prevention. The second response signalled supports as being very important: *okay have you got good supports at home, do you have a bit of time out for yourself, do you and your partner get to go for coffee once a week?* (4CHN). In contrast to the previous examples, this second participant specifically noted that encouraging parents to have time out with their partner once a week just to de-brief was important. However, in these and other examples, there were no clear indications that mental health promotion was being acknowledged when using the early detection screening tool as a springboard to broader conversations.

5.3.4 *Perinatal depression resources*

This concept of perinatal depression resources, within the subtheme ‘policies and protocols embedded in a mental illness framework’, relates to other resources as described by participants that were used in mental health promotion. On a number of occasions in the interviews, participants alluded to the use of perinatal depression resources, such as Beyondblue brochures and formal support structure referrals as being part of their mental health promotion. As with the EPDS, participants stated that they often used the resources as a way of beginning a conversation about mental health promotion.

An example of these discussions included a child health nurse’s use of a brochure as a way of ‘flagging the issue’: *when they have a baby we would always ask them if they have had any issues with mental health*. Again, it is significant to note that she articulated mental health as illness and thus turns to an illness awareness and prevention brochure to support this in her practice: *maybe not go into it much, but just flag it off, “Here’s the little brochure about it. Have you had an issue in the past?”* (7CHN).

At the time of the data collection of documents (usually concomitant with the interviews), there was a number of resources available that discussed perinatal depression and these were given to parents in the parenting packs prior to and post birth in all State regions. I also observed a number of Beyondblue posters around the midwifery wards and in the child health nursing clinics.

During the time I obtained these resources, I collected the Beyondblue pamphlet ‘*Emotional health during pregnancy and early parenthood*’ as part of the parenting pack given out to parents in the perinatal period. At the beginning of this brochure were five pages that discussed what to expect in pregnancy, birth and early parenthood and within each area were terms such as ‘*common concerns*’ or ‘*women may find it more difficult if...*’, together with a discussion on expectations. There were then two pages that were more in keeping with Jahoda’s (1958) examples of positive mental health that looked at advice for new mums – *getting organised, getting support, staying healthy, managing stress, taking time out, considering your own needs, and being good to yourself*. There were then twelve pages that discussed

emotional health as mental illness early detection, prevention and finally treatment. This imbalance between promotion of mental health and early detection/prevention of perinatal depression, in the main external document available to parents, is consonant with the emphasis given by midwives and child health nurses in this study.

In contrast to this emphasis on raising awareness of illness, was the fatherhood brochure 'HeyDad – Fatherhood first 12 months' by Ngala (a Western Australian provider of early parenting services) and Beyondblue which emphasised a more holistic discussion on strengths such as discussing relationships and attachment theory. There were also some other brochures within these parenting packs about playgroups and Chat'n'Walk (pram walking groups). However, when I asked the participants about mental health promotion, I wasn't directed towards these with an explanation of how these activities would build social networking and the informal structure of peer support; the Beyondblue brochures were the main brochures perceived as mental health promotion.

5.3.5 ObstetriX database (midwifery)

A final concept within the subtheme 'policies and protocols embedded in a mental illness framework' centred on participant responses regarding the ObstetriX database. This tool was part of the midwives' daily protocol and was commonly mentioned in midwives' responses regarding mental health promotion. The ObstetriX clinical database system is currently used in the Australian states of New South Wales and Tasmania as a way of recording and storing parental data. In particular, the database is a surveillance system that tracks and manages maternal and neo-natal data from pregnancy through to birth and is accessible by all maternity health care workers in hospitals and General Practitioners (Monk et al. 2013).

Within the ObstetriX database is a section that relates to an assessment that midwives are required to complete when they admit a parent into the hospital system. One midwife described how she saw this tool as supporting mental health promotion: *there is a section in ObstetriX that's about a history of mental health problems and there is a big long list of things there.* She then stated that this part of ObsteriX was *like a trigger although I don't think that's the best way to approach it by saying do*

you have depression, do you have anxiety? (21M). This example denotes mental health promotion as being about illness awareness and prevention and is similar to other responses about ObstetriX as relating only to risk assessment for the development of a mental illness.

5.3.6 Child health surveillance

Tasmanian child health nurses are required to perform a number of health and development checks on infants and children at the following recommended ages: 2 weeks, 4 weeks, 8 weeks, 4 months, 8 months, 12 months, 18 months, 3 1/2 years (DHHS 2014). Child health nurses are guided by the checks in the 'blue book' which is given to new parents at the birth of their child and is known more formally as the 'personal health record'. The DHHS recommends that parents bring their children for these checks (terminology used is *'these checks are offered to parents'*) as *'babies grow rapidly and minor difficulties can become serious health or developmental problems if left'* (DHHS 2014). This book was first published in 1995 and reprinted in 2010 and is divided into five sections: contents/appointments, consultation notes, health information, growth charts, and assessments.

The contents/appointments section is a table of contents and a page with a grid/table allowing parents to write in their appointment dates and times. This section also includes a *'dear parent (congratulations on your new baby)'*, *'your rights (to health, confidentiality and privacy)'*, *'need help (emergency contact numbers)'*, *'child health services in each state of Australia'*, *'contact numbers for parenting lines'*, and the *'Child Health Association Tasmania (CHAT) information'*. In the consultation notes section, there are blank pages for both parents and child health nurses to write notes about the checks and a page in which a number of developmental milestones such as *'smiles'*, *'babbling'*, *'rolls over'*, *'first tooth'* are noted – with an area left for parents to write notes about these milestones.

Within the section entitled 'health information' are a number of pages that discuss the following issues: *safe sleeping (Sudden Infant Death Syndrome)*, *sleeping and settling*, *crying*, *breastfeeding (and blocked milk ducts/mastitis and storing human milk)*, *feeding with bottles*, *starting solid foods*, *minor ailments*, *your child's teeth*,

keep your child safe, sun protection, car safety, toilet readiness, postnatal depression. The final sections refer to per centile charts that track the growth (weight, length and head circumference) of the infant/child and the routine assessments or ‘checks’. These checks are described as *‘health assessments (which) are one way of identifying concerns about your children’ (DHHS 2010).* In each health assessment, or check, there are ‘topics for discussion’ around the time of the assessment (at 2 weeks, 4 weeks, 8 weeks, 4 months, 8 months, 12 months, 18 months, 3 1/2 years) and these relate to the cognitive, social and physical development of the child and are entitled *‘These are topics you may wish to discuss with your Child Health Nurse’*. Of all the topics, there is one recurring towards the end of each list of topics (at each health check) called *‘maternal health/wellbeing’* that parents *‘may wish to discuss’*. Finally there is the issue of immunisation, information about vaccine preventable diseases and a vaccine record.

Of greatest interest for mental health promotion within this personal health record is the information given by the parent run volunteer service ‘Child Health Association Tasmania (CHAT)’ which commenced in 1917. In this information, the Association states *‘would you like to: have fun, make friends with other families in your area, find out what’s available in your community for you and your children, get lots of information and tips on child development, health and parenting?’* They also state that they have *‘pram walking groups, CHAT and play sessions, family outings, information sessions, and resources libraries – all at various locations around Tasmania.’* These activities depict clear evidence of community initiation and engagement. Furthermore, they include social networking with free access Tasmania wide and also state that advocacy for parenting is part of their remit (chatas 2014). Hence the information within the personal health record describing the work of the CHAT depicts a strong inclusion of mental health promotion for parents in Tasmania, should they partake in CHAT’s activities.

There is little evidence, in terms of guiding comments within the health record, that any form of mental health promotion is delivered other than the information provided by CHAT. The personal health record appears to be based on surveillance charts that were instigated in the 1980s (Jeffs & Harris 1993) with little evidence of inclusion of more recent bio-ecological and strengths-based frameworks. These health checks

form a crucial part of reassuring parents that their children are developing at ‘normal’ rates and importantly pick up any deviations for onward referral. However, they do little to promote current parenting capacity other than through reassurance and health literacy: although both of these are important. Overall, the record is discourse-oriented to ‘*concerns*’ throughout the document rather than strengths, in turn guiding the child health nurse to discuss only concerns and the parent to discuss only deficits. Identification of concerns and deviations from the norm is crucial in the care of families, in order that they receive appropriate care and so this personal health record is a key tool for child health nursing and for parents – but not for mental health promotion.

In short, I am highlighting that again child health nurses are using a protocol which is effective in bringing parents to the service, only for the protocol to be deficit-based and as such parents only engage in ‘what causes illness’ as opposed to ‘what creates health’.

5.3.7 Antenatal parenting classes

The final concept in this second subtheme entitled ‘policies and protocols embedded in a mental illness framework’ illustrates that antenatal parenting classes are labour (birth or intrapartum), and transition to parent-oriented. The analysis of these classes included such areas as formal and informal support structures, psychological hardiness and stressors (Antonovsky 1979), resilience building, optimism, self-esteem and good marital relationship (protective factors NHMRC 2008), community engagement and participation, and strengths-based discussions (Smith 2011). There were some instances of strengths-based practices throughout some parenting classes although a medically oriented emphasis on labour content predominated – again reinforcing findings from antenatal education studies (see *Chapter Two*).

An analysis of parenting classes’ documents from the three main birthing hospitals in Tasmania elicited brief outlines of the topics for discussion in these classes, which usually take place over a five week timeframe and usually from 32 to 36 weeks gestation. In line with global studies investigating antenatal education, there were no syllabi or established evidence based rationales for the topics. Overall, I was given

parenting classes' topics (that parents receive) on one to two pieces of paper (some as pamphlet format) and the accompanying brief lesson plans (averaging one page of directions to each week's one to two hour long lesson) that the midwives taking the classes followed. Overall, the weekly topics in order from week one to week four/five included: stages of labour, pain relief strategies, exercises (Physiotherapist-led) for labour, pharmacological pain relief, unexpected outcomes in labour, breastfeeding, maternity unit tour, immediate postnatal care, what happens in hospital, practical tips of parenting: settling techniques, safe sleeping, getting support and learning how to ask for it!, and finally postnatal depression.

Examples of mental health promotion within these lesson plans included:

1) *transition to parenthood, stress reducing conversation activities, and the importance of fathers* – all topics which were based on the 'Bringing Baby Home' information package by the Gottman Institute which places a strong emphasis on the quality of the parental relationship due to Gottman's extensive studies on parenting relationships from the 1960s to present day; 2) *expectations about parenting*, usually facilitated by a volunteer from Good Beginnings, an Australian volunteer organisation that was founded out of NAPCAN – National Association for the Prevention of Child Abuse and Neglect whose core values are child focused, strengths-based, local ownership, inclusiveness and collaboration, evidence-based practice, innovation and learning (Good Beginnings 2014); and 3) *thinking about the future and encouraging parents to discuss how they celebrate special occasions in order to understand parenting styles and self-care in the postnatal period* – both topics taken from Birth International's Essential Educator Book, a package designed by ACE graphics and the Associates in Childbirth Education (Robertson 1997).

Although the majority of content within the antenatal classes' outlines and lesson plans focus on labour, there is a clear inclusion of material related to increasing confidence in parenting and to exploring how to strengthen the parenting experience overall. The inclusion of subject matter more closely aligned with mental health promotion, as opposed to perinatal depression signs and symptomatology, is encouraging. However, a stronger promotional framework with an evidence base that ties together all the pieces of mental health promotion would bring greater gains to this valuable construct.

5.3.8 Discussion

Anticipatory guidance is an important education tool in both child health nursing and midwifery practice (McMurray 1993). It is a form of education and support given to parents that can include a number of suggestions about what the parents can look out for in themselves or in their children in the coming days or weeks in relation to parenting. In terms of health promotion it is health education and can take the form of a discussion over developmental milestones regarding nutrition, feeding patterns, sleeping patterns and the like. The aim of this process is for parents to develop personal skills, described by the Ottawa Charter as one area of health promotion (WHO CPHA 1986), in anticipating what the future holds and to apply some ideas from child health nurses and midwives to counter or support the next phase of their child's development (Hagen et al. 2008). It is also a time when parenting health professionals have the opportunity to promote mental health or wellbeing in their clients. This promotion could be through a discussion of self-care, sleeping, informal and formal support structures and ways to build psychological hardiness (Antonovsky 1978) within a strengths-based framework. Significantly, there is currently a dearth of literature that examines how mental health promotion is addressed through anticipatory guidance in midwifery and child health nursing. Certainly studies of anticipatory guidance would be difficult to evaluate, specifically regarding health outcomes, due to the conversational manner of anticipatory guidance and the often hidden content within (McMurray 1993; Brennan 1998; Shepherd 2011).

A key finding from this study regarding the practice of anticipatory guidance within midwifery and child health nursing is the extent to which this concept followed an illness-orientation in the interviews. Anticipatory guidance in both midwifery and child health nursing documents was also found to be inconclusive regarding mental health promotion due to inadequate content description. Thus, an implication from participant practice of anticipatory guidance could be that its application in mental health promotion is an illness 'hammer' guiding and responding to mental illness prevention 'nails'. Overall, what this inadequate guidance incurs is an individualised interpretation of '*emotional support*' tabs and child health nursing topics, which potentially confers great variance in practice.

A finding of illness-orientation was noted within the family (child health nursing) and psychosocial assessments (midwifery). This finding is important as, given that most of the anticipatory guidance by both services occurred when using these tools, it raises similar points to those of anticipatory guidance in practice; of education within the two assessments as defaulting to illness awareness.

The family assessment form contains a statement: *in applying an ecological model, all CHAPS professionals have a responsibility to assess family situations for the presence of psychosocial factors known to place children at risk and the protective factors which may offset those risks (DHHS 2011)*. This wording is representative of an epidemiological basis of risk assessment and is at odds with a strength-based approach (Barnes & Rowe 2013). For example, family strengths language includes such expressions as ‘appreciation and affection’, ‘spiritual wellbeing’ and ‘commitment to the family’ (DeFrain & Asay 2007; Smith & Ford 2013). These expressions are in contrast to the questions which included words such as ‘*concerns*’, ‘*difficult*’ and ‘*worried*’. These are important considerations as mental health promotion aims to incorporate strengths-based approaches (DeFrain & Asay 2007) and such concepts as fortigenesis (Strumpfer 2006) and flourishing (Keyes 2007) as opposed to a population-based approach of identifying risk factors. There is also the question why risk and strengths were used together when they are potentially conflicting frameworks.

In the broader context, there is little evidence base that guides midwives in their overall care of parents, with the postnatal timeframe described as particularly under-researched (McLachlan et al. 2008). Emotional care is the term given to the majority of midwifery research that examines a parent’s mood and behaviour within the perinatal period (Gamble et al. 2005). Gamble et al.’s (2005) randomised controlled trial study was conducted in relation to emotional care of new parents and is a critical study in terms of mental health care provided by midwives. However, the term ‘emotional care’ is not really about promoting parental strengths but about *assessing* a parent’s emotional state. There is no research to date that examines how the mental health of a parent is promoted by midwives in the antenatal clinic or postnatally on the ward, thus underscoring the need for this current study.

In summary, there was little evidence to suggest that mental health promotion occurred within either service within or guided by these assessments. It certainly could be argued that a discussion on strengths and flourishing could have taken place outside of the directions of both assessment tools and that the use of open-ended questions within the family assessment allowed for this. However, this discussion was neither represented in the interviews nor in the assessment tools. This underrepresentation of mental health promotion in the services' two main protocols is worrying, if for no other reason that its omission could indicate one reason why perinatal depression rates remain at around nine per cent antenatally and 16 per cent postnatally, in Australia (Buist & Bilszta 2006). In line with Antonovsky's (1979) question "what creates health" as opposed to what creates illness, the question 'why do 91 per cent and 84 per cent, respectively, of parents *not* develop perinatal depression?' appears, hitherto, to have passed by midwifery and child health nursing researchers. The reasons why this may be the case are explored in *Chapter six*.

The EPDS tool was discussed at length in *Chapter Four* where it pertained to participants' understandings of mental health promotion. In this discussion, the tool is explored as how it influenced practice. The EPDS, developed in 1987 (Cox, Holden & Sagovsky), and validated for parents within the perinatal period, asks parents to rate feelings of i) *happiness/laughter* and ii) *looking forward with enjoyment* in the first two of ten questions. It then moves to asking parents to assess feelings of *self-blame, anxiety, worry, fear, panic, unhappiness, sadness* with the final question asking *about self-harm*. Although many participants discussed being able to talk with parents about feelings of anxiety and perinatal depression that might have been revealed from the scale, there was little evidence that participants used the first two questions about happiness and enjoyment as springboards to a greater discussion about strengths that DeFrain and Assay (2007) espouse. Buist et al.(2006), who developed and evaluated the Beyondblue's four year programme (2002-2006), which included the Australia-wide use of the EPDS within perinatal care, indicate discussion arising out of the tool is part of the screening's purpose. However, a discussion of promoting a capacity that already exists would be greatly hindered when an illness discourse is its proponent – and certainly this was the case with the EPDS in this study.

There is little research that discusses the use of adjunct tools (such as the brochures and pamphlets collected) in promoting mental health, although there has been evaluation of the use of these Beyondblue materials (Beyondblue 2008) in perinatal depression awareness in health professionals; this evaluation is beyond the scope of this study. However, one study did identify that child health care workers were more likely to distribute brochures and pamphlets instead of addressing issues within their working routines (Lagerberg et al. 2008). Overall, it was again evident that the tools (brochures and pamphlets) that midwives and child health nurses used to discuss their perception of mental health promotion were in fact oriented towards illness awareness and prevention and not mental health promotion. This is an important issue as it attests again that if your only tools are about illness then all your discussions will be about illness.

Although there is a number of reports and articles that discuss the use of ObstetriX to obtain data (St George Homebirth 2007; NSW Ministry of Health 2012; Monk et al. 2013), it is difficult to obtain any studies or reports that discuss how the ObstetriX database was developed and in particular upon which evidence base each section was created.

The ObstetriX database was perceived by many midwives as a barrier to mental health promotion and I write about this in greater detail in *Chapter Six*. What is significant in this chapter is that the tool directed participants to discuss mental illness history and that there was no provision for talking about the promotion of current and future parenting capacity. Implications from this include parents only being asked about a history of mental illness with no scope given to a discussion on strengths and their capacity to parent from these strengths. This is a significant finding as this database forms the basis of the majority of communication by midwives with parents in the antenatal period and again reinforces an illness hammer with illness-dependent nails.

So far, in this discussion, I have explored the literature that examines the five protocols (governed by DHHS policy) indicated by participants as being representative of supporting mental health promotion in their services. The following paragraphs include a review of the literature that investigates the personal health

records of child surveillance; one of the two concepts that were highlighted as not promoting mental health. Finally, a brief summary (Chapter two has a greater review) of literature regarding the other concept of antenatal parenting classes will be presented.

A report commissioned for the Victorian Government's Department of Education and Early Childhood Development (2010) states that the personal health records drive the child health nursing engagement with parents by providing a schedule of contact "with an emphasis on prevention, promotion, early detection and intervention for health and wellbeing" (p.5). The report found that the main functions of the personal health record – used extensively throughout Australia and in a number of countries worldwide (Bjerkeli et al. 2006) – are to "improve access to health information, improve communication between the child's care providers, improve parents' engagement in their child's health care, and improve health service utilisation" (p.22). However, the report concluded that only a small number of parents regarded the personal health record as supporting their communication with all health professionals. Furthermore, the report recorded that "there is no empirical evidence that using a CHR improves health outcomes or health service use, with the exception of improved vaccination rates" (p.22).

It appears that one of the main reasons for the continued use of these records is due to parenting demand to have a record of child development (Saffin et al. 1991), and in one convenient location (Stacy 2008). However, there is more to this practice than just 'holding a record of a child's development in one place'. This personal health record is about surveillance and not a neutral and objective instrument of surveillance (Wilson 2001). The act of surveillance is problematised in child health nursing literature, foremost through a discussion of science and scientific discourses (Dingwell & Robinson 1993). More recently, surveillance has been examined through Foucauldian discourse analysis on power relationships in surveillance (Wilson 2001; Peckover 2002; Davis & Allen 2007) in which, as part of their roles, child health nurses visit parents' homes. Both discourses (scientific and power) have relevance to this protocol that is used to increase engagement with the child health nurse and aims to increase positive outcomes for parents and their children. An examination and explanation of the broader social, cultural and historical conditions in which

surveillance in health visiting/home visits occurs within child health nursing is beyond the scope of this thesis. However, what is noteworthy with regards to the protocol of child health surveillance and health education within the personal health record is the discourse that earlier created and now maintains this protocol and how that ties into the current discourse of mental health promotion.

The personal health record began as a measurement of hygiene practices (see also *Chapter Two*) due to the influence of medicine and its efforts to decrease infant mortality. It was also lauded as a way of parents gaining more control over the decisions made about the health care of their children (O’Flaherty et al. 1987; Kim et al. 2011). What is concerning is that this surveillance was prioritised over other practices within child health nursing and this prioritisation of child health screening and development assessment is arguably still manifest today (Schmied et al. 2011). This continued prioritising (which is discussed further in *Chapter six*) could be best explained by highlighting that health surveillance is debatably a dominant discourse. Surveillance and education (informing the public of what they ‘need’ to know) was, and potentially still is, driven by a powerful culture of medicine and thus is a “regime of truth” that Foucault highlights “determines what counts as important and relevant” (Foucault 1980, p.131).

In short, it could be argued that the personal health record was only created to do exactly what it does: screen for deviations away from the norm, for illness and refer if any are found – two areas that were representative of medicine-based health surveillance whose aim was to decrease rates of child morbidity and mortality (Mein Smith 1997). The health education topics within the personal health record are based on an ‘information sharing’ non-participatory (Arnstein 1969) model and potentially include topics that have been in place for over 80 years with the underlying tenet ‘to educate the mothers’ (Barnes et al. 2003) still underscoring the practice. Although it has been argued over the past 20 years that child health nursing has moved on from this deficit-based discourse of surveillance and risk, there appears to be little movement in this study and in broader usage (Schmied et al. 2011). Greater incorporation of bio-ecology and socio-ecological models (such as Bronfenbrenner 1979) as discussed in McMurray (2011), need to be incorporated within such a

strategic and prioritised tool in child health nursing if mental health promotion is to receive a less marginalised position in parenting education.

5.3.9 Summary of the subtheme regarding policies and protocols embedded in a mental illness framework

Within this chapter, this second subtheme of policies and protocols embedded in a mental illness framework described how a mental illness emphasis is entrenched within the policies and protocols of these two Tasmanian services. Five practice tools were identified by participants as being used to promote mental health promotion. These tools/documents, part of the documents collected as a second form of data, were then analysed for mental health promotional content. The analysis of interview data ascertained that participants' understandings of mental health promotion in practice included using anticipatory guidance, the psychosocial and family health assessments, the EPDS, the perinatal depression resources from Beyondblue, and the midwifery ObstetriX database. This analysis of both the interview and document data elicited a strong illness-orientation as opposed to a mental health promotional emphasis. Finally, two further documents that were not highlighted by participants in their responses – but were part of parenting experiences within the two services – were analysed for mental health promotional content: child health surveillance book (child health nursing) and antenatal parenting classes (midwifery). These two documents showed some indications of mental health promotion as relationship building. However, there was a notable absence of guiding detail in both document forms, and thus no real conclusions could be formed whether mental health promotional information was outlined with parents.

5.4 Conclusion

This chapter is the second of three findings/discussion chapters. The first chapter explored the first major theme regarding how the complex construct of mental health and its associated *terminology* impacted upon its usage by midwives and child health nurses and thus potentially on parental experience of this construct in Tasmania. This second chapter discussed the second major theme: default mental illness framework and focussed on the *practice of mental health promotion* as perceived by

the midwives and child health nurses. Two subthemes discussed within this second major theme included participant examples of practice as being embedded within a mental illness framework, and the policies and protocols that participants used as being embedded within a mental illness framework. There were a number of concepts discussed within these two subthemes such as risk factors, (mental) health promotion, knowledge construction and workplace structure. Furthermore, five protocols (determined by overarching policies) were identified by participants as mental health promoting and included anticipatory guidance, family/psychoassessments, EPDS, perinatal depression resources and the midwifery database ObstetriX. Finally, a document analysis for mental health promotional content was performed with the child health nursing child surveillance book and the midwifery antenatal parenting classes' information.

How language is used in turn influences how it is received. Furthermore, how it is received can lead to significant follow-on effects. *How* mental health promotion terminology has been incorporated within the tools that are then used in perinatal education practice by midwives and child health nurses can influence how the practice of mental health promotion impacts upon parents' understanding of, and access to, this valuable construct.

Significantly, there is a clear disconnect between research and what is actually practised. Mental health promotion research is gaining ascendancy and yet there appears to be a 'pot luck' scenario under the current models of care whether parents engage with a midwife or child health nurse with a strengths-based approach or a mental illness default. Certainly, there is a responsibility by midwives and child health nurses to ensure that practice matches contemporary best evidence. In the next and final findings/discussion chapter the '*why*' of this illness-orientation will be explored and some potential solutions to this mismatch will be presented.

Chapter 6

Findings and discussion: Barriers to mental health promotion

Complicit?

“Was wollen sie von Mir? Ich bin doch nur Schauspieler!”
(What do they want from me? I am just an actor...)



Movie 'Mephisto' (1981) based on Mann's novel 'Mephisto' (1936)

If the reader is familiar with Klaus Mann's novel *Mephisto* (1936) and his deeply, troubling Faustian theme of a popular, German actor making a disturbing pact with the Nazi regime in the late 1920s, then he or she will be wondering what the link could possibly be to a final findings and discussion chapter on parenting. I am not aiming in this chapter to draw links to the deep violence of Klaus Mann's novel and the Nazi regime; I am not making a contextual link. However, actor Hendrick Hoefgen's consternating comment at the end of the novel, above, resonates deeply in regard to my third and final theme: barriers to mental health promotion in perinatal education. At the end of the Mann's novel, Hoefgen states that he doesn't know what the Nazis want from him; he's just an actor and not responsible for any consequences arising out of the controversial acting roles he plays or from his fraternising with Nazi leaders. The reader is left to ponder his culpability and complicity. It could be that midwives and child health nurses, too, need to ponder why mental health promotion is apparently underrepresented in their services and their potential role in this.

6.1 Introduction

This study utilises a critical approach and thus looks to the ‘why’ as much as it does to the ‘what’ and ‘how’. So far my findings have been representative of *not* being ‘much ado about nothing’ but rather, being much ado about a lot with regards to contested understandings of mental health promotion. Often, too many elephants in boa constrictors’ stomachs have been interpreted as hats. Could a limited lens of an inherited perinatal depression framework be at fault? This final chapter questions whether there is some complicity at play and, if so, *why*.

Vandenberg and Hall (2011) remind me that in representing findings of participants – the midwives and child health nurses who took part in the interviews – that representation has consequences and how people are represented is how they will be treated. Thus, I am mindful that how I interpret data will have implications and consequences because “these things matter” (Madison 2012, p.5). Therefore, I postulate, with awareness of representation, that there could be some analogous link to Hoefgen’s naivety (Mann 1936) within the health system and within the early parenting services. Could it be possible that midwives and child health nurses ‘go along with the flow’ and are party to unquestioningly following a hospital unit’s or a community nursing’s framework? There are many instances within the data where this conclusion could be drawn, as discussed in *Chapters Four and Five*. However, to say that midwives and child health nurses in this study are potentially complicit in their under-provision of mental health promotion is to vastly underestimate the forces around them which influence their understandings and their practices of this construct.

The data from this study suggest midwives and child health nurses are, on the whole, deeply passionate about supporting parents through conception to the birth of their children and onward through the early parenting stages, as encapsulated by the following comment, *because we’re motivated, we’re educated, we really want the best for our clients (3CHN)*. Significantly, there are some issues in the data that appear to stymie the passion in the participants for supporting parents in mental health promotion, as best they try. Furthermore, the data suggest there are other issues that are potentially out of their control. It could be argued that eventually,

‘things can get too hard’; midwives and child health nurses can lose motivation for mental health promotion and retreat for very good reasons. Some of these reasons and *why* they impact on supporting the interests of parents receiving mental health promotion are discussed in this chapter. Whether midwives and child health nurses are complicit or not, may be a moot point.

Hitherto, the findings have been suggestive of the ‘what’ of definitions and terminology of mental health and mental health promotion in *Chapter Four* and of the ‘how’ of mental health promotion in midwifery and child health nursing practice in *Chapter Five*. In this chapter, the ‘why’ or, perhaps more notably, the ‘why not’ of mental health promotion in midwifery and child health nursing is discussed. In doing so, this chapter highlights and examines the final and most significant of all three themes within the findings: barriers to mental health promotion. The findings are significant not only in terms of number of responses and time devoted by participants within the interviews to this area, but also because the issue of barriers pervaded the interviews regardless of the questions.

This chapter describes the findings regarding this chapter’s theme of ‘Barriers to mental health promotion’, through a discussion of how the Tasmanian Department of Health and Human Services (DHHS) midwifery and child health nursing models support or inhibit mental health promotion for parents. In this chapter, I also posit some reasons, based on this study’s data and other research, into the reasons why ‘things get too hard’ for participants in promoting mental health in parents and in doing so, discuss implications of these barriers for practice.

Four main barriers to mental health promotion from the data include: 1) communication barriers, 2) inadequate time 3) medical influence, and 4) incongruent models of care. Within these four barriers were a number of concepts as set out in the table below, and highlighted for this chapter.

Chapter Six

Complicit?

MAJOR THEME	SUBTHEMES	CONCEPTS
Barriers to mental health promotion	Inadequate communication	Barriers to building therapeutic relationships
		Barriers to communicating with parents
	Inadequate time	
	Medical influence	
	Incongruent models of care	Workforce barriers
		Target platform
		Inadequate funding
		Structural practice barriers
		Acute care practices

6.2 Inadequate communication

This first subtheme within the chapter ‘Barriers to mental health promotion’ presents the finding that midwives and child health nurses described inadequate communication as being problematic for parental mental health promotion. There were two concepts within this first barrier to mental health promotion: a) barriers to therapeutic relationship building and b) barriers to communication with parents.

6.2.1 *Barriers to therapeutic relationship building*

This first concept of inadequate communication relates to a therapeutic relationship as a vital tool in communicating the promotion of mental health to parents. This finding demonstrates that there are barriers to building this relationship with parents. These barriers included i) inadequate acknowledgement in policy and protocol of the importance of building a trusting relationship, and that ii) funding was not directed in

either service for the provision of building this relationship. There is an abundance of literature (largely within mental health nursing due to its emphasis on this concept) that establishes the positive impact that an effective, therapeutic, trust-relationship can have on patient/client health outcomes. Examples of studies concerning therapeutic relationships include Lally's (1989) mixed methods study on the schizophrenic patient's perspective of care, O'Brien's (2000) hermeneutic phenomenology of nurse-client relationships: the experience of community psychiatric nurses, Kirk & Glendinning's (2002) in-depth interviews of parents caring for children with complex needs, and most recently Lees et al.'s (2014) qualitative surveys and interview data on therapeutic engagement between consumers in suicidal crisis and mental health nurses. Many participants who raised the concept of a therapeutic relationship indicated that they were aware of the evidence-base for the importance of building one and the crucial role that the relationship played in their work. Moreover, many of the participants discussed this relationship as being, potentially, the most important aspect of their care.

As a way of establishing the importance of therapeutic relationship, one participant described how one of her colleagues had been working *for many years and that the uptake of her services is fantastic because they have got to know her and trust her (1CHN)*. Another participant stated that *it all stems back to the relationship I think you have with the client*. She then described a situation where this 'all' was significant in that when parents were screened (EPDS), she noted *if you haven't got a good rapport with them, you're not going to get an honest answer (4CHN)*. Many participants discussed how effective communication stems from a trust relationship. One participant began by stating that her relationship with parents *is not a relationship of dependence, that it was a trusting relationship and one that I absolutely respect (6CHN)*. Another described how important a one-on-one relationship supported communication when, as a post discharge midwife *I usually see the same mum on each visit. So, by the second or third visit I usually develop a relationship with them*. I asked her what this would mean in supporting parents and she explained that *if I say to them, "how are you going"? they'll tell me; they can just go for it – they can disclose things (28M)*.

This importance of disclosure, brought about by a positive therapeutic relationship, was also particularly the case with one child health nurse who was part of the cu@home teenage parenting programme (DHHS 2009), in which the nurses were able to start to support the parent in the antenatal period and then continue on in a one-on-one relationship with the parent: *I think definitely the antenatal visits are really good because you actually get to know them before they enter the busyness of parenting.* She then described how one parent could have been interpreted as suffering from depression. However, because she knew her well from before birth *she's so much better than what she was before. That's the advantage of knowing her before (13CHN).*

In short, a number of participants signalled that effective communication took place when a trust relationship with parents was established. Moreover, they indicated that promoting mental health (which, as previous findings in *Chapters Four and Five* indicated, could be both promoting strengths or awareness-raising of perinatal depression prevention) would only be effective when the midwife or child health nurse was able to build this type of relationship and when the parent felt comfortable and safe enough to hear what the participant was saying. As one of the participants (CHN4) alluded, if a parent does not score the reality of his/her feelings on the EPDS nor discuss any issues that the EPDS raises, a breakdown in this screening occurs. This example highlights the importance of a positive, therapeutic relationship and one in which the parent feels comfortable to disclose and thus has the potential to receive support and/or treatment for PND.

Most significantly, whenever some participants talked about the importance of the therapeutic relationship they also discussed how there was inadequate acknowledgement by policymakers of this vital area of communication with parents. In particular, hidden or covert conversations were important in building therapeutic trust relationships and were an area that participants claimed were not acknowledged as important. Representative of participant responses was this one from a child health nurse: *these are not conversations that policy makers have any clue about or any appreciation of and they probably sum up most of what we do.* Furthermore, this participant argued that these conversations do not *show up on the data during our*

checks, so there's just no real acknowledgement at all of all the affirming and supportive kind of conversations that go on (16CHN).

A number of child health nurses were also critical of how a decrease in funding (decrease in clinic hours) affected the building of trust relationships. Child health nurses noted this happening through a decrease to the amount of days that parents were able to access particular clinics. For example, when clinics were made to close for one day every week, this meant that every full-time child health nurse needed to attend other clinics in order to make up her time allocation and thus commence with new groups of parents each time: *I think the problem with some centres, having too many people seeing parents, you know, like sharing your story...and you don't want to share your story over and over (6CHN).* Participants saw this issue of parents not being supported by a one-on-one relationship, meaning a new nurse with each appointment, as hindering the building of a therapeutic trust relationship and in turn undermining the parent/nurse relationship to support mental health promotion.

This first communication concept of inadequate communication denotes how participants described a therapeutic relationship with parents as a crucial part of their role, and one that arguably has a significant impact on parents' care. This concept relates to why inadequate therapeutic relationships potentially impede mental health promotion. This inadequate relationship building is noteworthy as it poses a threat to the protocol of communication that is crucial in midwifery and child health nursing. This concept also depicts how funding and workplace constraints can encroach on the development of a therapeutic relationship.

Inadequate communication is a significant finding due to its emphasis on building trust in a relationship with a parent in order for the relationship to be effective and thus the care to be explicitly of value to a parent. If the therapeutic relationship is not respected in these services by policy and funding, then the implications of a decrease in communication could potentially impact both midwives and child health nurses, leading to demotivation. It could also lead to their connection with parents becoming subservient to the tasks they carry out. Furthermore, any hope of securing a relationship where deep, meaningful exchanges unearth issues that need to be

explored will likely cease to exist as will the potential for strong, supportive ongoing encouragement of strengths-based promotion and flourishing.

6.2.2 Barriers to communicating with parents

This second communication concept includes three barriers that participants identified as hindering the support of mental health promotion in parents: i) the act of completing paperwork within both services, ii) inadequate midwifery education about how to communicate with parents, and iii) inadequate privacy for midwives when talking with parents. In these three barriers, paperwork pertained to all forms of assessment for both services; midwifery education related to both tertiary education within midwifery qualifications and professional development; and inadequate privacy concerned midwives within hospital admissions (antenatal care) and on the ward (postnatal).

One participant highlighted how completing paperwork intruded on her communication with parents: *I find that forms that you have to fill in can be inhibiting, you know, because it's not the way I work... it's a barrier to communication, my communication.* She then described how the forms that she needed to fill in meant that *I can tick off the box that it's done*, but that in doing so she argued that she was *doing it for my benefit. So that's like putting my stuff first (8CHN)*. This response highlighted how the act of completing paperwork dictated the way communication happened between parent and participant as opposed to being consumer-initiated. This barrier has important implications as emerging evidence suggests that consumer-initiated communication or more widely touted as patient – centred (Proctor et al., 2014), is a vital part of allowing the parent to secure the care they want as opposed to institution-driven agenda.

The midwifery ObstetriX data system was also seen to be a hindrance to communication with parents with one midwife discussing the system as *really limited* and thus *it depends on who does the interview and what they write down, a woman's history, mental health history (2M)*. One child health nurse described her frustration in not being able to promote mental health as *the way we operate we're just so full on with all the paperwork and assessments there seems to be very little*

real opportunity for us to do much else (16CHN). Finally, another participant vented her frustration:

I'm worried that we're going to spend so much time doing the paperwork that you haven't got the time to really spend doing..., yes it's good to have the stats and all that. But are we losing sight of that person and I'm a bit frightened by that...I don't want to be sitting here writing while someone's trying to spill their guts (6CHN).

On the whole, many participants described paperwork as a barrier to engaging with a parent and thus being able to converse where the consumer could lead. For the most part, communication was instigated by the assessment tools and participants felt that they were not free to discuss any of the questions in detail and allow the parent to stray 'off course'. Furthermore, and of more serious import, was the way paperwork appeared to be obstructive in meeting duty of care; that paperwork was the imperative and *someone trying to spill their guts(16CHN)* was secondary. Although some of these paperwork examples relate to mental illness awareness and support, the barrier of paperwork can still be recognised as a deterrent to conversations that could include a discussion of ways to promote wellbeing in parents.

Inadequate in servicing or tertiary education around communication for midwives was noted as a barrier to communicating with parents. One midwife described how communication was undervalued within professional development and thus in her role. She maintained that when professional development regarding communication was raised in the workplace it was usually to do with *culture and immigration, but, not a lot on just 'how' we talk*. She commented further that *we need to learn how to speak a different way. But how do we do that? I would love to see some language skills, learning so that we can start (10M)*.

Although scrutinising midwifery tertiary courses for mental health promotion was not within the scope of this study, it was significant to note that only one midwife discussed education around communication within their tertiary midwifery studies, and that it was not addressed in their professional development. In contrast, a number of child health nurses discussed their C-Frame (communication techniques) (Victorian Parenting Centre) inservices and how helpful they were to elicit information from parents. A perceived inadequacy of education and professional

development around communication is important to note, as it raises the potential that communication and engagement with parents may not be currently emphasised or supported in practice. This possible omission further highlights the question of, on which evidence and within which framework do midwives currently communicate with parents about mental health promotion? Certainly, this understanding of the 'how' of communication did not seem to be universally understood by a number of participants in this study.

The third barrier to communicating with parents was privacy. This pertained only to midwifery practice as the child health nurses worked in an environment where they had privacy to talk with parents. The midwives in this study worked in a hospital environment with a number of participants critical of the conditions: *the location was terrible to have the conversation as you are always squashed in some small office somewhere*. She also commented *that with other children jumping about, there are problems and disrupted conversations (22M)*. Another participant stated that parents started conversations in the waiting room and that the common response to the parent was that *this was not the best place to be dealing with this – where can I sit you down and have a chat?* However, *there is not enough space to have that personal, confidential conversation* and in trying to find somewhere the midwife commented that *the conversation is delayed by abrupting (sic) that conversation, you are losing the flow and you might not elicit all the information that was going to be shared (18M)*.

This third concept highlights the challenge that midwives have in trying to secure privacy for conversations with parents. The midwives discussed this concept as a barrier to promoting mental health in parents, as it was a challenge to find a private location, incurring the consequence of midwives not being able to elicit sensitive information from parents. In not being able to do so, midwives were not able to ascertain what concerns the parents had, and thus were not able to best support them. Again, as with the barrier to paperwork, this barrier around privacy concerns pertains mainly to mental illness and support thereof. However, this barrier can still be recognised as a deterrent to conversations about mental health promotion that initially require privacy to understand the strengths that each parent brings to parenting.

The second concept of barriers to communicating with parents, within the first subtheme of inadequate communication, identified three barriers to communication that midwives and child health nurses considered hindered their promoting of mental health in parents. The barriers of completing paperwork in both services, inadequate education about how to communicate with parents and inadequate privacy for midwives when talking with parents were described by participants as substantial issues to resolve in order to provide effective care. It is an important finding as all three areas of completing paperwork, education about communication and discussing care with parents in private, are crucial processes that midwives and child health nurses require in order to perform their roles. Mental health promotion necessitates communication be prioritised. However, this finding suggests that too much paperwork, apparently negligible tertiary or professional development on communication techniques with parents, and inadequate privacy for conversations and support impedes the effectiveness of exchanges regarding mental health promotion with parents taking place.

6.2.3 Discussion

Trust relationships are determined by one person having trust, or positive expectations in another's competence and also feeling assured that the person in whom he/she has put the trust will act in his/her best interests (Calnan & Rowe 2004). A therapeutic relationship is one in which this trust would be manifest between midwife/child health nurse and parent and thus arguably crucial in encouraging a parent to utilise both services and, as Rowe & Calnan (2004) contends, to disclose personal information that will enhance care. Significantly, a trust- relationship would directly influence health outcomes due to parent satisfaction and continuity of midwife or child health nurse (Safran et al. 1998; Simpson & Creehan 2008). However, what is of most importance is that successful communication between parent and midwife/child health nurse is dependent on the nature and strength of this relationship (Clendon 2009). Furthermore, in order to build this relationship, there needs to be time allocated within a midwife's/child health nurse's role (Zerwekh 1992; Falk-Rafael 2001). When a therapeutic relationship is in place, a therapeutic alliance of collaboration between parent and

midwife/nurse is achieved in order realise parental goals (Doherty 2009), particularly in midwifery care (Doherty 2012).

Critiques of the therapeutic relationship in early parenting have included concerns about power differentials (Wilson 2001), that the nurse has dominance within the relationship due to invasive surveillance practices (Oberle & Tenove 2000), especially those which take place in the parent's home (Marcellus 2004) and with those families who are deemed at-risk (Larchienko 1994). However, although control of communication usually remains with the child health nurse (and by extrapolation the midwife) through such means as ignoring parents' questions, most of these critiques relate to the *workplace structures and protocols* that hinder communication and support nursing control in this relationship and not the child health nurse, him/herself. Examples of this 'control by protocol' include deflecting the conversation onto selected topics (De la Cuesta 1994) and adhering to schedules of questions (Cowley & Houston 2003). These critiques are in contrast to those studies which focus solely on the positive outcomes a strong therapeutic relationship brings to parents (Jack et al. 2005).

Although there still appears to be a strong emphasis on surveillance within both Tasmanian midwifery and child health nursing services, as described in *Chapter Five*, a stronger emphasis on psychosocial (Fowler 2005) and bio-ecological determinants (Li et al. 2009) has been occurring over the past two decades, globally. Inextricably linked to these approaches are the therapeutic relationship and the significant processes needed to build it: attracting the parent to the child health clinic, entry work (to a parent's house), getting to know the parent, settling in the relationship, and finally, developing mutual trust and creating connectedness (Briggs 2006-7, pp.306-7). In this finding regarding barriers to building a therapeutic relationship, two areas were highlighted by participants as vital: both time and processes in place in order to build this relationship. Moreover, many participants argued that both time and processes of establishing this relationship as outlined by Briggs (2006-7) were not recognised by policy makers as important. This finding reinforces literature that corroborates that in order to establish rapport, convey respect, promote commitment, participate and build trust (NSW Health 2009, p.9), time and continuity are important (Schmied et al. 2009).

Mental health promotion is largely dependent upon the relationship and communication that exists between midwives and child health nurses (Ruddick 2013). This promotion is especially effective when parents are supported to acknowledge their resources (Ruddick 2008). Promotion is also successful when parents are encouraged in self-management, personal empowerment and control, are supported to identify coping strategies that have worked for them in the past, and/or encouraged to embrace new strategies that promote wellbeing (Copeland 2000). However, what is noteworthy in these studies by Ruddick (2008) and Copeland (2000) is that the emphasis is on the midwife/nurse developing these skills. There is little literature that discusses the time and processes (policies, protocols and supportive environment) that already need *to be in place*, that is, already articulated in policy and funded in order for the nurse/midwife/parent relationship to be built initially and then maintained. Significantly, it had been described as an aspiration only, or ideal (Marcellus 2004) that this ‘environment of relationship building’ is realised for sustained engagement with parents.

The first concept within the ‘barriers to communication with parents’ finding relates to participants’ perceptions of data recording or completing ‘*paperwork*’ as being detrimental to foundational communications in midwifery and child health nursing. This finding reinforces the literature that highlights how ‘paperwork’ intrudes upon the processes of relationship building (Briggs 2006-7). In particular, what has been described as the ‘burden of paperwork’, has been under examination in a number of nursing studies, in which nurses complain how the time spent completing “lengthy admission forms, patient care plans, complex discharge planning documents and a plethora of risk assessments” (Robertson 2012, p.22) decreases their ability to engage meaningfully with parents. In particular, Congdon & Magilvy (1995) discuss the documentation burden in rural community nursing; McVicar (2003) reviews literature on workplace stress in the UK health service; Rupert & Baird’s (2004) study that found that paperwork was the greatest stressor in the mental health field; and finally Carise et al. (2009) evaluated the significant burden of paperwork in addiction studies. Furthermore, overburdened nurses describe emotional exhaustion and burnout (Rupert & Morgan 2004) and challenges associated with paperwork completion (Kantarowski 1992). Another complication of completing data recording is what Darbyshire (2004) calls the ‘rage against the machine’ (p.17), in which staff

working with computerised records report feeling powerless to influence how the databases support them and their clients.

In short, timeframes of over four hours of paperwork have been described with simple admission assessments for many health professionals (McLellan et al. 2003) compromising time spent in communication (Cypres et al. 1997). These excessive timeframes represent a detrimental mode of care delivery that further impedes active listening and parent focussed and initiated care that could support mental health promotion.

Another barrier of communication that the midwives noted was *inadequate education* in their university education and/or in servicing regarding *how* to communicate with parents. This finding centred on a lack of confidence in talking to parents about emotional health and the ways in which midwives, and to a lesser extent child health nurses, need greater access to professional development in order to gain self-assurance in this area. This education about emotional health is in its infancy in Australia, with proposals to incorporate mental health literacy into university courses only gaining currency recently (Johnson 2014). However, this incorporation of mental health literacy will affect mental illness communication as opposed to a focus on promotion of wellbeing.

A program of advanced communication skills (ANew) was implemented in a Melbourne midwifery unit in Australia in 2003 and has been evaluated since (Gunn et al. 2006; McLachlan et al. 2011). However, the findings pertained mainly to perinatal psychosocial (illness) issues, with increased self-reported comfort of midwives identifying and caring for women with psychosocial issues.

Communication skills are critical for an individualised approach to midwifery care (McLachlan et al. 2011) and particularly for active listening and supporting parents to disclose sensitive information (Yelland et al. 2006). However, evaluations of the ANew program do not specifically discuss communication skills that directly influence strengths assessments, which can require a greater knowledge of the interplay of family, community and environment (Barnes & Rowe 2013).

Furthermore, there is no research that investigates how midwifery education (about communication) supports mental health promotion.

A final barrier to communicating with parents involved midwives' perceptions of inadequate privacy as impacting upon their ability to promote mental health in parents. This finding of inadequate privacy in communicating with parents is reinforced in a number of recent studies that have examined psychosocial assessments in midwifery. In these studies, inadequate privacy was reported to have impinged upon a nurse's ability to sensitively support a parent's care (Yelland et al. 2006; McLachlan et al. 2011). Although there are no studies that report on a lack of privacy in a discussion on mental health promotion with parents, a parallel could be drawn from these other studies, that privacy would be needed when implementing a form of strengths-based or parental capacity-building assessment.

6.2.4 Summary to subtheme barrier of inadequate communication

A therapeutic relationship is an essential part of supporting effective engagement with parents. Without the prioritisation of this process within the two services in Tasmania, it could be argued that effective mental health promotion cannot take place. Furthermore, feeling overburdened with the process of filling out paperwork, inadequate communication education for midwives and inadequate privacy in the workplace decreases the ability for both midwives and child health nurses to engage on any meaningful level with parents. These communication barriers are described in similar ways within established nursing and midwifery literature and thus this finding reinforces many of their conclusions. However, it is important to note that in many instances the previous research was generalised or mental illness-oriented and that mental health promotion was not the concept or construct under examination.

6.3 Inadequate time

MAJOR THEME	SUBTHEMES	CONCEPTS
Barriers to mental health promotion	Inadequate communication	Barriers to building therapeutic relationships
		Barriers to communicating with parents

Inadequate time	
Medical influence	
Incongruent models of care	Workforce barriers
	Target platform
	Inadequate funding
	Structural practice barriers
	Acute care practices

This second subtheme, within this chapter's major theme 'Barriers to mental health promotion', describes how inadequate time in their role impedes midwives and child health nurses being able to perform their assessments and thus promote mental health in both services. In particular, inadequate time responses denoted ineffective care and many participants held concerns as to whether their care could be deemed negligent.

Firstly, one midwife described her practice and inadequate time as *trying to ascertain how they are, have they got issues and all that, and you've got, like, an hour*. She found the time allocated to this part of her role as very constraining as *there was so much that I needed to tell them, how much support I needed to give them*.

Furthermore she described her practice as *we're task orientated and we're time poor and it's not a good recipe, is it?* However, her final comment summarised many other midwifery responses regarding mental health promotion when she stated:

we're looking at how big is the baby, when is she due, is she a positive blood group, has she got HIV, ticking all the boxes. Do we have the crown to rump length to make sure that her EDD is absolutely correct? All those sorts of things, I just sort of think, by the time you've done all that to even then consider the mental "How are you," "How's things going? Are you right?" (19M)

This example, representative of a number of participants' responses, highlights why a task-oriented framework, and perceived inadequate time to fulfil these designated tasks can potentially impact upon mental health promotion. In essence, this midwife is stating that mental health promotion pales into insignificance against the tasks that are required to be performed as per the antenatal schedules. It also reinforces, as

illuminated in practices discussed in *Chapter Five*, that mental health promotion is not one of those tasks.

Another midwife commented that *we don't have the time sometimes to literally sit with the patients (23M)*. Furthermore, there were common stories shared by many midwives whereby they felt compromised in their care due to inadequate time: *we only get 25 minutes...we are really bang, bang, bang. We have to finish. A girl walked in and just burst out crying and so it's really hard when you gotta keep doing things*. In particular, one midwife was very concerned how inadequate time affected her care regarding a parent's wellbeing:

you probably won't ask sometimes...I mean, you do ask how they are feeling, but you might get a lady who says, "I'm fine" (soft voice) and if you are really running half an hour late, you leave it at that... but if you've got a bit of time and you've got to know them a bit, you might ask "are you just okay?" And that is very much influenced by how you are feeling at the time. (28M)

This example denotes how inadequate time influences a form of participant disassociation from their parents in order to perform their tasks within the designated timeframe – recorded by the midwife above as 25 minutes. This example also highlights how enforced timeframes and 'running half an hour late' impact upon the delivery of care that parents receive. Thus, the subtheme of inadequate time, in this instance, places demonstrable, adverse pressures on both midwives and parents. This subtheme has implications for mental health promotion as it would appear that in not having adequate time mental health promotion remained potentially unaddressed.

Some child health nurses also remarked how inadequate time affected their support of parents. One, in particular, stated that *I'm working all the time trying to promote their health and we're really under the gun for time. So it's boom, boom, boom*. On the whole she found that *you don't really have that much time to promote self-responsibility. You're trying to get all your paperwork done, get the baby weighed and all that stuff too (5CHN)*. Another participant stated that due to inadequate time it was *a bit of a worry that you might end up very focused on the baby and the health checks because they're looking at the data to the detriment of other issues*. Of most

concern was her description of something she witnessed as a student child health nurse:

I was once a student with someone and could see that the mum was tearful. The nurse was doing a health assessment on the baby and she kept her head down and kept writing and didn't look up and I thought 'do I say something or not say something'? I didn't say anything. And when the mother went I said 'she had tears in her eyes, she wanted to cry'. And the nurse replied 'I didn't have time to do anything for her - so you don't ask (12CHN).

The above experience impacted upon this participant significantly. She argued at the time of the interview that it was important she highlighted this example as she felt how inadequate time still affected support of parents and that this same inadequate time in practice to complete all the protocols had not changed since her student days. Certainly, these two examples above by child health nurses reinforce the concerns of the midwives in this study about an inability to promote parental health due to surveillance requirements. It is noteworthy again that neither in child health surveillance and assessment, nor in midwifery task-oriented schedules (ObstetriX) did mental health promotion have a voice due to the prioritisation of other issues.

Finally there were examples that illustrated how *often we don't have time to scratch the surface*. This superficial attention to care concerned one child health nurse:

We don't have time to find out that their partner, who is a merchant seaman, is away for six and back for six, that his mother, you know, is a cow and just saying "Okay. Well, who else? You know, have you got a cousin that you've lost touch with 'cause she's just had her three babies? Who have you got?" (15CHN).

This child health nurse indicated that inadequate time in her role diminished her ability to move to a deeper level of conversation with parents and thus elicit more targeted information about informal supports. This inability to procure important information about informal supports, which have an important role in the promotion of mental health, reveals a significant oversight in the care of a parent and is suggestive of why parents can be at risk of not receiving the level of care required for their needs.

Furthermore, another child health nurse described how *if you're in a rush I don't think you get any mental health work done because people pick up that you're in a rush so they won't tell you their problems (13CHN)*. In this conversation the child health nurse expressed concern that time affected how much support she could give parents. She indicated that an imposed schedule rendered her 'rushed' and that parents then considered that they weren't being 'heard' and so remained silent about issues with which she could potentially help them.

This final example of inadequate time aligns with the concept of therapeutic relationship formation. However, in this instance, the child health nurse sees time as having an impact on the way she conducts an assessment as opposed to *how* she engages the parent. In this example, the implication is that inadequate time forces her to act in a way that diminishes her ability to obtain any information about mental health and thus of discussing ways of promoting her mental health. Furthermore, inadequate time appears to create angst in the participants due to compromising their care. Thus, I reiterate the notion that 'things can get too hard' for these key providers of perinatal care, and when so, a demotivation to fulfil vital task-related criteria possibly occurs.

6.3.1 Discussion

Inadequate time to perform nursing care is a commonly reported problem within nursing literature (e.g. Forest 1989; Robinson & Hill 1995; Tovey & Adams 1999; Bowers et al. 2001) and thus this study's finding reinforces other studies regarding this issue. In particular, one UK midwifery public health study found that the shortage of time available, clinically, to care for women affected similar areas as this study, including the difficulty of "providing copious health promotion messages at the booking interview, the 'tick box' approach to care, and midwives' reluctance to develop conversations with women due to a lack of time" (McNeill et al. 2012, p.5). Time constraints can enforce a form of prioritisation of discussion topics (Calloway 2007) as it is easier (and therefore quicker) to discuss such topics as car restraints or folate nutrition than it is to allow parents time to discuss sensitive issues. Additionally, if this sensitive information then requires referral, then time is needed to do this process as well. Both midwives and child health nurses could feel

potentially overwhelmed with these required interventions and thus hesitate to address them in the first place.

Furthermore, a number of Australian midwifery studies that specifically discuss the protocols of practice (assessments) that this study's participants perform, found that inadequate time decreased not only the quality of these assessments but also whether they were carried out in the first place. Specifically, this barrier to midwifery care included a decrease in undertaking the EPDS (Jones et al. 2012), identifying and responding to women with psychosocial issues (Yelland et al. 2006), and emphasising the importance of spending time listening to women and providing sensitive and supportive care (Beake et al. 2005; Yelland et al. 2006; Schmied et al. 2008). However, Schmied et al. (2008b) found that the barrier of inadequate time related not just to psychosocial issues but to broader areas of relationship building and therapeutic engagement through an acknowledgement that parents were wanting more time to engage on a one-on-one basis in order to discuss issues other than physical surveillance (Forster et al. 2005; McKellar et al. 2006).

It is a similar situation with child health nursing literature and an inadequacy of time to engage more fully in the protocols of the service. However, a more significant feature of the changes to the model of care (further discussed in this chapter under the concept of target platform) that many other states within Australia have already experienced, is how an increase of targeted (priority of risk) home visits have decreased the ability of child health nurses to instigate and support first time-parent groups. Parents argue that these groups allow for "opportunities" to build informal and formal structures of support with other parents and the child health nurse (Guest & Keatinge 2009, p.17). This inadequate time provision for socialising with other parents has potentially allowed, in other Australian states, for an increase in social isolation. It could also be argued that inadequate time provision has meant that mental health promotion's voice of "personal competence, perceived control, sense of stability, recognition of self-worth" and self-efficacy through these groups (Langford et al. 1997, p.9) has been ignored.

6.3.2 *Summary of subtheme of inadequate time*

Decreasing timeframes for effective care is an acknowledged theme throughout nursing with recent studies noting this issue in both midwifery and child health nursing services. This finding illustrates how inadequate time impedes the performance of assessments and the initiation of protocols, such as first time parent groups and thus hinders potential mental health promotion. It is an important finding as time is needed to build trust in a relationship with a parent in order for the relationship to be effective. Without the necessary time being apportioned to these services for relationship building and opportunities for purposeful conversations to take place, mental health promotion fails to gain any ‘voice’ within the two services and in turn parents are precluded from the opportunity to build upon their strengths. The broader determinant of allocation of scarce resources impacts upon the provision of time for both services – firstly, in midwifery, due to its function as an acute care service (discussed in detail later in this chapter) and secondly, in child health nursing where services have been redirected to address Selective Primary Health Care targeted at risk populations.

6.4 Medical influence

MAJOR THEME	SUBTHEMES	CONCEPTS
Barriers to mental health promotion	Inadequate communication	Barriers to building therapeutic relationships
		Barriers to communicating with parents
	Inadequate time	
	Medical influence	
	Incongruent models of care	Workforce barriers – NEEDS SH
		Target platform
		Inadequate funding
		Structural practice barriers

The dominance of the biomedical model of care (cure) and its practitioners (doctors) continues to be supported as a social script politically, economically, and socially, despite the centrality of the nursing resource

(Porter-O'Grady & Malloch 2006).

This next subtheme of medical influence within this chapter's major theme of 'barriers to mental health promotion' highlights the potentially detrimental impact on mental health promotion of the influences of medical dominance and a biomedical framework in midwifery and child health nursing practice.

There were a number of responses which described the biomedical model as being a hindrance to mental health promotion for parents due to its non-holistic approach. Most of the responses for this finding of medical influence emanated from midwives. For example, one midwife discussed how the biomedical framework uses a systems approach and that *as midwives when we learn about women, about birth and pregnancy, women are separated into little pieces and we learn about little pieces*. She stated that *it's the way we're taught about it*. Furthermore, she described how the biomedical approach was incorporated throughout antenatal care, arguing that *a lot of antenatal care is typically foetal surveillance and maternal surveillance and yet care involves a lot more than just physical surveillance and looking at the physical parameters*. Finally, this midwife commented that much of the antenatal education centred on *preparing a woman for a series of procedures that's going to happen to her in hospital, preparing her for something that's described in purely medical terms (10M)*.

Another midwife described her work as *very much medically- oriented in the sense that we focus on the physical health; it's not so much mental health*. Similarly she discussed practice as being *very much focused on the immediate, you know, bleeding, contraceptives; all this physical stuff, but in terms of keeping healthy, getting on with your parenting role and getting to know your baby, we do a very poor job, I think (14M)*.

The biomedical framework is embedded heavily within both services through the adoption of routine schedules or clinical pathways that include the term 'surveillance' to describe the care given to foetus, infant and mother throughout the perinatal period. In Tasmania, child health nurses follow a schedule of appointments with parents which commence within the first week post discharge. Midwives follow specific frameworks called schedules in the antenatal period, and then within the intrapartum (labour/birth) and postnatal periods they follow clinical pathways. Many participants discussed how routine schedules of surveillance, and the tasks within this surveillance process or clinical pathway, were both supportive and a hindrance to mental health promotion. Some child health nurses commented on how the 'baby checks' (surveillance) helped them to talk about other issues and this has been noted as hidden or covert conversations (Shepherd 2011). However, more common was the complaint that these schedules interfered with mental health promotion:

It cannot be a standardised care package that every person that walks in the door has a normal birth, gets two sleeps and they're out the door. Every person who walks in the door has a Caesar, gets four sleeps and they're out the door. I think a little bit of support and nurturing at that point, means you won't get them bouncing back into kids ward with feeding issues, with parenting issues, with acopic issues; if you've done that promotion and support, then they know where to go for help (15M).

Each of the three examples just presented within this concept of medical influence highlighted particular issues with the biomedical model that concerned them. In the first example, the midwife was concerned that in breaking down a parent's health into physical elements, there was no holistic overview of the parent. This has implications for mental health promotion in that the construct incorporates many diverse understanding of cultures and beliefs and is non-aligned with a biomedical model that uses a systems approach incorporating surveillance of, mainly, physical parameters. The second midwife criticised the medical model for being very focused on the present (and mostly physical complications) to the detriment of any anticipatory guidance for the future. In being thus focussed, she contended that parents fail to receive supportive information about their parenting after discharge and again, physical parameters are emphasised to the detriment of a holistic overview. The last example highlights the emphasis on a timeframe for the hospital

admission as being a ‘standardised package’ and thus how parents are packaged (not parent-initiated) into receiving the care that the hospital institutes. This adoption of institution-driven care means that those who implement the medically dominated policies and protocols become potentially complicit in doing so. However, it also means they ultimately have little choice but to do so, when there is little choice in what they have to implement in the first place. Furthermore, it means parents have fewer choices, leading to potentially no voice whatsoever in the type and content of care they receive.

6.4.1 Discussion

In this subtheme, medical dominance (Friedson 1970; Evans 1983) has arguably negatively influenced the roles of midwives and child health nurses and the content of their work and in turn parents, as consumers of perinatal education. Although some bio/socio ecological concepts are encountered within the child health nursing sphere (Schmied 2008a), biomedical frameworks (Mischler 1989) that hinder mental health promotion were still perceived by participants to be visible and dominant in midwifery care. It is acknowledged that nursing practices are determined by the dominant discourses of medical professions (Powers 2002; Tovey & Adams 2003; Hyde et al. 2005 in Whitehead 2009) and that these practices are governed by biomedical frameworks (Mischler 1989) that do little to support broader determinants of health and health promotion. Furthermore, medicalised tasks, with their “biomedically oriented diagnosis and treatment regimes” are given greater prioritisation by management and policy structures as they appear to be more respected than health promotion (Whitehead 2009, p.122). These prioritisations from biomedical origins within general nursing are transferable to midwifery and child health nursing due to a number of factors of which medical dominance is one.

Medical professional dominance and autonomy are viewed to have decreased in the past three decades within Australia due to concerns over patient safety and increased health consumerism (Germov 2002). However, in broader terms, control, subordination of other occupations (Coburn 1992), sovereignty over all matters to do with health (Willis 2006), together with a subjugation to structural interests in which “institutions of society operate” (Alford 1975, p.14) are arguably still embedded

within midwifery and child health nursing care delivery. Doctors are the “gatekeepers” (Willis 1983;2006) of both of these professions within the healthcare system of Australia, due to their governance over diagnosis and treatment – “enshrined in Australia’s medicare system” (Willis 2006, p.424) – and control over evaluation of care (Harrison & Armad 2000) of families and children. As such, the medical profession from its early alliance with civil servants in the 1940s (Colwill 1998 cited in Harrison & Armad 2000), is one structural interest that determines how both parenting services in this study are organised and administered – potentially subjugating health promotion to the dominance of detection and treatment of physical illness (Whitehead 2009). This dominance in ‘all things mental’ is particularly the case in Australia where access to primary mental health care is ‘gatekept’ through the Division of GPs in policy (Reifels et al. 2012). Another competing structural interest is “economic rationalism” (Willis 2006) or neoliberalistic funding and that is addressed later in this chapter.

Lewis (2006) contends that medical dominance is still evident in Australia:

“While many claim that the medical profession has lost power in health policy and politics, this analysis yields few signs that the power of medicine to shape the health policy process has been greatly diminished in Victoria.

Medical expertise is a potent embedded resource connecting actors through ties of association, making it difficult for actors with other resources and different knowledge to be considered influential” (p.2125).

This dominance can be viewed at the level of a midwife or child health nurse as an inability to make decisions about the care he/she delivers (Long et al. 2006). In particular, the delivery of care still appears to participants to be organised in such a way as to hinder a Primary Health Care framework of parent-centredness, and access to midwives and child health nurses when needed. It could be argued that this impediment of Primary Health Care principles is due to biomedically-focussed surveillance practices that appear to have restricted midwifery and child health nursing to task-oriented praxis. Institutionalised expectations drive these practices (Cowley et al. 2004). As both services in Tasmania are governed by ‘structural interests’ both locally, state-wide and federally that are arguably medically dominated (e.g. specifically in midwifery see Fahy 2012), expectations will run

along surveillance and risk assessment lines – and for the most part physical surveillance (Hanson et al. 2009) as described in *Chapter Five* regarding the child surveillance book (child health nursing) and clinical antenatal, intrapartum and postnatal schedules and pathways (midwifery).

6.4.2 Summary of the subtheme of the barrier of medical influence

The effect of the medical influence on nursing is well documented globally and there has been much discussion over many decades about the creation of nursing holistic models to counter the influence of a biomedical approach. In recent times, midwifery models of care have attempted to incorporate the overriding goal of Primary Health Care by incorporating women-centred principles of care. In doing so, midwifery aimed to move away from medically dominated models that do not prioritise a more holistic provision of care. Child health nursing claims to do the same – in their case, family centred – and to have greater ability to do so within their community-based setting that arguably allows for greater access to them by parents. However, some participants in this study contested how successful these attempts at being founded upon a Primary Health Care framework have been – culminating in questioning how well parents are engaged and supported by these services, when the vestiges of medical dominance continue to pervade the two services and arguably oppress salutary interests. Significantly, surveillance and risk-based assessments that are prioritised by policy in both services leave little room for communication, therapeutic engagement and health education – and thus little time for mental health promotion.

6.5 Incongruent delivery of care

This final subtheme within this chapter's major theme 'Barriers to mental health promotion' was the most significant in terms of the number of responses regarding barriers throughout the interviews. Participants argued that the way care was delivered governed both services and did not serve their interests in promoting mental health as midwives and child health nurses, and thus in turn, the interests of parents. Many of the elements that constitute the way care was delivered were also

incongruent with the care that midwives and child health nurses desire and are motivated to perform. There were five concepts that underpinned this incongruence: i) workforce barriers, ii) target platform for child health nursing, iii) inadequate funding, iv) workplace structural barriers, and v) acute care practices for midwives. All five concepts reinforce currently limited findings from evidence in literature regarding this incongruency in midwifery care and to a lesser extent in child health nursing delivery of care.

6.5.1 Workforce barriers

This first concept regarding incongruence in delivery of care relates to the amount of work that is needed to be done and the actual number of midwives or child health nurses employed to do the work. It highlights how there was inadequate acknowledgment in workforce education regarding how mental health issues affected how midwives and child health nurses carried out mental health promotion. Both midwives and child health nurses described how a limited workforce (staffing) impacted on their own workloads and thus the amount of time they had available for mental health promotion. They also identified that there needed to be more recognition of how mental health promotion actually affected the midwives and child health nurses themselves, sometimes to the point where they were unable to discuss mental illness with parents. Both midwives and child health nurses recognised that the health promotion they desired to impart was impeded by these issues.

Participants argued that not having enough workforce (midwives/child health nurses) to support parents left them frustrated that the best care was not being delivered. One child health nurse described that *our core business is, and our KPIs (key performance indicators) are, all around child health assessments and we've got a workforce that barely covers that*. Furthermore, she maintained that when needing to do child surveillance with a parent who couldn't attend the clinic that *we haven't got the flexibility to do home visits for every check. So that is a constraint*. She went on to note that *if we did (a) we would hopefully engage more, and (b) we'd have more opportunity for health promotion, whether it was mental health promotion or physical (3CHN)*. A midwife noted that with there was a push for early discharge as *there is certainly pressure to get women in and out because we haven't got the beds*

and probably a lack of staffing (2M). She was concerned that such a small amount of time on the ward meant that little mental health promotion took place.

This concept was a significant barrier as it affected whether a parent was able to gain access to a child health nurse or midwife due to constraints around staffing. Child health nurses were also limited in their ability to engage with the community, requiring for the most part the community (where possible) to access them in the clinics. This barrier has implications for access to these important services when parents are at their most vulnerable. It is difficult to say whether this non access and pressure for discharge contravenes duty of care, but it is certainly worth considering as a form of potential neglect.

There was inadequate acknowledgement in workforce education regarding how the topic of mental health promotion could have a detrimental effect on midwives and child health nurses. Participants argued that there was inadequate recognition for how certain practices/protocols affected those who implemented them.

One participant reflected a number of responses about the two services needing to acknowledge more how staff feel about some areas of their practice, including mental health promotion: *you know if people (midwives or child health nurses) haven't dealt with some of their own issues then it's very hard to be open and listen to other people's and so I don't really think the service has dealt with that fact.* She claimed that *it's just assumed, you would do this, it's part of your job, you do it. Not really individually asking people, can you manage this? Is this okay for you to do? (9CHN).*

This concept, within the subtheme of workforce barriers, of a non-acknowledgment of personal issues highlights how both midwives and child health nurses are required to raise a number of areas within their assessment forms with parents such as mental illness, intimate partner violence and child abuse. In particular, this concept illustrates that midwives and child health nurses have little access to debriefing about such confronting issues. It therefore questions whether individual midwives and child health nurses are asked about their abilities to raise these issues and when they do, are they coping with doing so. An inability to discuss mental illness would have implications for mental health promotion in that (as discussed in *Chapter Four* and

stigma) this construct may not be attempted and thus parents will not receive promotion of wellbeing.

Inadequate access by parents to important services due to workforce constraints and discharge from hospital imperatives are serious limitations for the two services examined in this study. These limitations are serious as they impinge on parental access to services when they are potentially needed most and could imply that these constraints confer on midwives and child health nurses an inability to promote mental health. Mental health promotion is also a possible topic of anguish and worry for some midwives and child health nurses and this concept of personal issues raises the question whether in-servicing education regarding mental health promotion in the two services needs to acknowledge potential anguish or concern. Certainly, this non-acknowledgement could in turn potentially affect the delivery of care to parents if child health nurses and midwives avoid more than a token engagement with mental health promotion.

6.5.2 Target platform

This next concept, within the subtheme incongruence of care delivery, relates to a barrier of mental health promotion that held significance for many child health nurses and related to their platform of universal care. At the time of the interviews (2011-2012) the Child Health and Parenting Service (CHAPS) was undergoing a review and many of the participants discussed the possibility of the service changing from an established (since the service began in the 1920s) universal platform to a targeted platform of risk and vulnerability. Child health nurses had attended '*information roadshows*' (ICHN) prior to the interviews, wherein the term 'vulnerable' was vigorously debated, with many attendees very vocal about the implications that a change of platform could signify. Many participants questioned the need for change and the top-down enforced approach, as suggested by the comment below:

Hey we're there for the people, we're not there to make the politicians look good. And yet somehow there seems to have been this shift in thinking that it's all about, you know, we need to keep the masters happy when, wasn't it meant to be about the people? Wasn't that always what a public servant was meant to be, serving the people? (16CHN).

Furthermore, in these meetings, many participants were informed that these at-risk parents would be targeted by CHAPS on a more intense basis, meaning a higher schedule of visits for these parents, possibly to the detriment of non-at-risk parental visits. Many participants felt that this targeted approach would erode the service's well recognised universal platform and in turn impact on universal parental access to the service.

Initially, child health nurses were most concerned with how the service was defining 'vulnerability' and 'at-risk'. Many participants stated that the term 'vulnerable', in the new model, indicated low socio-economic class and yet *the middle class, middle values...they're still vulnerable (6CHN)*. One child health nurse questioned *what is the definition of a vulnerable family?* and argued that *anyone has the potential to be vulnerable, so what does that mean? (12CHN)*. In particular, one child health nurse claimed that those of higher socio economic means were being dismissed in the new model as *the super anxious or the "worried well"* and that these types of parents should fund their own services. Furthermore, she remonstrated:

Who makes these definitions? When did it become acceptable to speak in a derogatory manner about any section of our community? I think it's a real problem...the idea that you could just dismiss a whole section of the community as the "worried well". How did that get to be right?(16CHN)

This participant also maintained that in the current, child health universal model the *underlying philosophy of being an advocate for all, for the idea of health for all* was important. She questioned whether access and service provision would remain for all: *are we primarily here for health or are we primarily an adjunct to child protection in terms of supporting families who have been deemed vulnerable? (16CHN)*

One child health nurse cited a scenario that had been discussed in the information inservice (*roadshow*) regarding the new model, in which *a woman who was a paediatrician and whose husband was an anaesthetist had a child who had a breastfeeding issue*. The situation was put to the child health nurses that there was also *a person who was living in a lower socio-economic area with a breastfeeding issue*, and they were then asked *who do you service first?* This participant stated that the child health nurses were directed that *you would service the low socioeconomic area first - but the reality is what is the difference? Why is there a difference when they both have needs?* She argued that although *one can afford it, and one can't, that it doesn't mean that the one who can afford it you cut out? When the service is there it should be universal (1CHN)*.

Another child health nurse had a concern regarding vulnerability that was echoed in others' responses. She stated that she understood why vulnerability was being targeted. However, she was still worried about the ones who wouldn't be deemed vulnerable at that moment. She argued that *the ones who aren't vulnerable now, who are seeming to do quite well because they are getting support and they are getting information, if they are going to be seen less, they are going to become vulnerable because they don't have the support that they used to have (24CHN)*.

Finally, one participant stated how an emphasis on vulnerability could impact upon health promotion: *we're supposed to be a universal service so therefore the health promotion stuff that we could do, instead we're going into these little pockets that are for more vulnerable people (6CHN)*.

It is clear that child health nurse participants considered the issue of vulnerability to have been problematised by policy makers. It is also apparent that there was much confusion as to how vulnerability would be categorised and this has also been an issue for midwifery policy where there is not always a clear consensus at the operational level as to who 'disadvantaged clients' are (Hart and Lockey 2002). However, what was also identified is that a universal platform confers health for all through open access to child health nurses and thus by inference, open access for all to mental health promotion. These participants recognised a selected or indicative platform as stymieing their ability to ensure that all parents received their

anticipatory guidance. This obstruction would have implications for the possible promotion of mental health within their anticipatory guidance reaching all parents.

6.5.3 Inadequate funding

This next concept within the subtheme of incongruence of care delivery, illustrates *how* the way the two services were funded was considered by participants to be a threat to promoting mental health in parents. Both child health nurses and midwives alike commented that current funding arrangements saw an emphasis on surveillance and health checks to the detriment of adequate time for communication and supporting parents. As discussed in the previous concept target platform, many of the child health nurses were concerned about a change to their model of care during the time the interviews were completed. In particular, there was a concern that first time mothers' groups were going to be discarded and this concern gained publicity during 2012. Social media, such as Facebook, played a role in ensuring that the new model incorporated these groups, although CHAPS maintained that that was always going to be the case and placed a notice to that effect on their website. Such was the concern of nurses and of parents that the public needed to be informed in this manner.

This concern about inadequate funding was evident in a number of participant discussions and many of these conversations considered decreased funding as perpetrating what they considered would be a very detrimental change to child health nursing and consequently to parental mental health promotional support. One participant stated that the mothers' groups were important for *networking; they can make links and don't then feel so isolated as a mum. I just think that that's really important for mental health promotion*. She then commented that this part of the service was *a bit devalued*. When I asked by whom she declared *by bean counters or accountants*. She claimed that those who were in charge of budgets considered that parent groups were attended only by *middle class people, so, let's get rid of them*. Furthermore, she argued that *to me that is one of the good things that we do with mental health promotion and it's undervalued by management (25CHN)*.

Some participants highlighted how erroneously money was currently being spent in the two services with one midwife stating that *if we spent as much money on postnatal support, as we do on antenatal surveillance, imagine the differences we could make (10M)*. In contrast, one child health nurse discussed how she considered *a good way of spending the health dollar* incorporated a parent being able *to just tell her story in a completely safe way, no expectation that anything else was going to have to happen about this*. She commented that when this happened in her clinic, afterwards the parent *looked like she was walking out with less on her shoulders*. She saw the service as providing a unique experience: *where else could she have had that opportunity? (16CHN)*

Some midwives raised the issue of short term funding. One in particular voiced her frustration that *there are all these little things that are happening everywhere and then the funding dries up*. She was concerned that mental health promotion was seen as only a short term proposal and then *let's move on..tick box...there's a lot of ticking of boxes and unfortunately a lot of it's not long term (22M)*. Another participant saw funding as *a political circle*. She used the then, upcoming state political election as a way of expressing her concerns about how funding cuts affected mental health promotion: *if we cut funding to elective surgery it might make a bit of difference for people. But if we keep cutting funding to child health and parent assistance it will have a huge impact, potentially (2M)*.

Another funding issue that was raised pertained to the structure of CHAPS within the overall funding state health budget. One child health nurse questioned the placement of the service within another service: *our budget is aligned with Youth Justice and Child Protection, so they use a lot of resources, that's how it is (12CHN)*. This example highlights an issue of importance as it signals a reason why health budgets dictate models of care and certainly why the acute end of services attracts greater attention and funding. The fact that a primary health care service is aligned and competes for funding with an acute care, highly utilised service is problematic.

Overall, one midwife's response was representative of a number of participants who were concerned that *the almighty dollar crept in and now it's "this person has been here for four days. Why is she still here?" "Well, she's struggling with coping." "Not*

our problem. Get her out of here” (15M). Many participants commented that a number of practices that supported mental health promotion had been discarded. As a final example of this, the practice of breastfeeding was particularly singled out by the same midwife as above, who denounced sending a mother home too early. She was critical of the non-recognition, in current practice, of the importance of supportive conversations that occurred during breastfeeding observance: *in the past you were expected to sit with a lady for a whole feed, you'd only have three patients, and you would watch and talk to them, and support them through each feed.* Of most significance was her concluding comment that in those days *we had this luxurious service (15M).* Her comment begs the question whether this service was indeed a luxurious one or simply a service that should be considered imperative?

This concept of inadequate funding, within the subtheme of incongruence of care delivery, illustrates how this deficiency affects the way mental health is promoted by midwives and child health nurses. In particular, participants were highly critical of the decisions by budget centres about where the emphasis in funding was placed. Certainly, it can be argued from their responses that there is little emphasis within budgets given to practices that promote the mental health of parents. Of great significance, and arguably concern, in funding priorities is the juxtaposing of a universal child health service and a highly specialist, indicative child protection service within the same budget centre as evidenced in the structure of the Children and Youth Services within the Department of Health and Human Services (DHHS 2012, p. 13). As with Malin's (1895) poem depicting a fence on a cliff or an ambulance down in the valley, it is vital to have child protection services as both fence (prevention) and ambulance (treatment) to protect and support children. However, this placement of the two services within the one funding arrangement again raises the issue of promotion becoming secondary to an overburdened service that potentially receives a far greater allocation of resources. Children continually, and rightly so, need a fence and an ambulance. However, for this protection service to occur, funding will be sourced from areas of universal prevention and promotion that have yet to prove their efficacy. Acquiring funding in the first place to realise promotional aspirations and then to evaluate them (outcomes of which are not easily measured in narrow, quantifiable-only measures) devolve to a 'vicious circle' that is never fully realised.

6.5.4 Workplace structural barriers

This next concept regarding incongruence in care delivery is complex and relates to many responses that identified why workplace structure is a significant barrier to mental health promotion for parents. Four areas within this concept were identified: i) the structuring of protocols, ii) inadequate flexibility, iii) inadequate peer support and, iv) inadequate interface and collaboration between midwifery and child health nursing.

This concept of workplace structural barriers identified that the structuring of protocols hindered mental health promotion. One midwife commented that mental health promotion needed to be overtly *part of the practice*. She stated that *even though you might have some kind of learning, professional development about something and it can be in the back of your mind, unless it comes into some kind of practice structure I'm probably not going to do it*. Conversely, she warned that parts of the structure, for example the EPDS, can become too routine and that *you don't actually ask enough questions around it and dig deep enough because you think, "Oh, that's good enough. I've filled the form. I can tick it off now"* (7CHN). This is an important example as it raises the consequences of mental health promotion not being structured within protocols, as identified in both interviews and document analysis in *Chapter Five*. The implication is that when it's not within the structures, it won't be addressed. The other example of routine screening causing communication with a parent to become complacent is more problematic. However, it raises the potential for a framework of mental health promotion to include the screening as just one part of a larger conversation and not as a single entity that has no relation to a whole mechanism addressing wellness.

Another midwife discussed how the ObstetriX program supported unity within service provision: *at least we are all asking the same questions – that's one good thing about the ObstetriX programme that the questions are there, they needed to be asked and you can't just jump over them because you have to put an answer there*. However, she became critical of how there was inadequate structural support in ObstetriX for mental health promotion due to inadequate detail: *as a midwife you can be looking through ObstetriX and unless it is meticulously documented 'has seen*

social work this visit please see entry on DMR', he/she might totally miss that that lady has even had an issue. She concluded by acknowledging that it was important for all programmes within the service to talk to each other (18M), so that a holistic picture of a parent, as opposed to a segmented one was viewable by all midwives in the service. This example, although pertaining more to mental illness notifications than promotion, highlights that the protocol of using the ObstetriX database is an important one as all areas must be addressed before a midwife can go from one area to the next. This is an important issue as it could potentially ensure that mental health promotion is addressed with parents. However, as the midwife above commented, there needs to be sufficient detailed information submitted within each area in order for all people who use the system to gain sufficient guidance how to best support parents. For example, there would need to be enough detail about parental and family strengths within, for anticipatory guidance to be shaped according to parents. The way in which ObstetriX was described by the midwife, did not seem to indicate that was the case and thus mental health promotion was possibly not achieved.

Another example of why the structure of protocols hindered mental health promotion is in the midwifery clinical pathway development. One midwife stated that *there is an item on the pathway that says, "psychosocial support" and that it was an in-house document*, but that there were no definitions or instructions. She commented that she was somewhat apprehensive that her understanding of what it was, *may be different to the next midwife working with me* and thus this pathway needed to be clearer for midwives in order that parents gained optimal support and education: *it would be helpful if the hospital had clear policies on what do to, and on how to approach mental health promotion, or even health promotion (14M).*

She also raised the issue of how these pathways do not foster *engaging the patient within the pathway. I think we dish out a lot of stuff and it's very one way; we're saying, "It's important for you," and yet we don't even ask them their opinion; it's about the checklist (14M).* I used part of this midwife's example within *Chapter Five* when highlighting the *how* in interview and document analysis that pertained to the midwifery clinical pathway and the 'what' of the 'psychosocial' tick box. In this chapter, this midwife's example is pertinent to *why* mental health promotion is potentially lacking in midwifery practice in this study due to inadequate protocols

that include the construct. However, two further issues in her example were also representative of some participants and included the engagement and participation of parents in their care. Participation and engaging of parents in their care is an important issue and she stresses conversely that midwives use a didactic approach to education and anticipatory guidance with parents. Furthermore, this example emphasises how mental health promotion is seen more as health education as opposed to engaging with parents and working with them to support their wellbeing, meaning that parents are crucial to their care and cannot be disassociated from the promotion of their mental health at any cost.

Another example of why the structure of protocols hindered mental health promotion was highlighted by a midwife who commented on how mental health promotion *needs to sit right across the whole spectrum of care* as opposed to only being raised during specific protocols. She pointed out that *I think the danger we have, and I've seen it in CHAPS with their breastfeeding education is you just got, oh, tick box, we've done that, don't have to do it again for the next three to five years*. In order to ensure that mental health promotion was in the forefront of the child health nurses' minds she argued that *it needs to be scattered throughout the year (15M)*. This example adds to a point raised earlier in this concept by a child health nurse that if mental health was not included in protocols then it would not be addressed.

However, this example goes further in highlighting why mental health promotion may have little voice in the two services: that it is potentially relegated to a one off education talk and then no longer incorporated in parental appointments/visits. Focussing on mental health promotion only once or twice within perinatal education diminishes how parental strengths and stresses change on a regular basis within the perinatal period. Secondly, it devalues the importance of this construct in promoting parental wellbeing and in turn, their children, their families and their community.

A second barrier to structuring a practice supportive of mental health promotion was inadequate flexibility. One child health nurse stated that she experienced far more flexibility within the community system than she did as a midwife in the hospital system. However, she commented that *we are getting more and more constraints put on us. You have to meet certain criteria, so we have to do all these health checks* and that the health checks fill the time allotted for each parent. She argued that flexibility

allowed for greater parental support: *okay we have a spare hour here, I know I've got a mum who needs some help so I can go out and do some home visits*. She was critical of the inadequate support for this flexibility to respond in a timely manner to any parental concerns; *so, you are looking at cars not being available, not having the time in the clinics to be able to do it (1CHN)*.

This example firstly raises the problem of constraints of structure within child health and the issue of surveillance checks filling the allotted parental visit. In identifying this problem of surveillance checks that the discussion in *Chapter Five* highlighted do not allow for mental health promotion, this example indicates why the construct is not supported in the service. Secondly, the example raises the issue of an inability to be adaptable to suit consumers; that consumers need to fit into the timetable of the service. The example also highlights how being unresponsive to parental concerns is potentially detrimental for parents.

The next structural barrier to mental health promotion is inadequate provision both time wise and within practice structure for midwives and nurses to support *each other*. Debriefing, multidisciplinary support and peer review were three areas mentioned as how midwives and child health nurses could support each other and thus be better prepared to support parental wellbeing. Participants who identified these three areas described them as structural supports that helped them in turn to be supportive of parents.

One child health nurse stated that *sometimes you need opportunities to talk with a multidisciplinary team to bounce ideas of a mental health nurse or to talk to a psychologist*. She then identified that *if there were more bridges across the program, we could discuss these complex cases*. She also commented that there was a need for more contact with peers *just to be able to talk just nurse to nurse, more than we are able to now (25CHN)*. Another child health nurse related a similar description: *extra debriefing and some peer support in terms of where we can have these conversations amongst each other (16CHN)*. Many commented that having these forms of support gave confidence to their practice, and in turn gave them confidence in communicating with parents; communication being a significant instigator of promoting mental health in parents.

Finally, one midwife raised the concept of the interface and collaboration between midwifery and child health nursing as being a reason why mental health promotion may not be well communicated with parents. She was concerned that there was a structural barrier regarding how information about parents within the services was communicated between midwives and child health nurses. She argued that there was a need *to put in place pathways for women, how they could be managed, in that intersection between the acute maternal postnatal ward and child health (14M)*. This issue pertains more to mental health prevention and intervention. However, it is an important argument and one that is still neglected in studies. It potentially questions how the nexus of care between both services could incorporate mental health promotion and strengths identification when there is *already* little existing interconnection regarding mental illness between the two services, with illness *already* having the priority.

In this concept of structural barriers to mental health promotion in both services, four barriers within this concept were identified: i) the structuring of protocols, ii) inadequate flexibility, iii) inadequate peer support and, iv) inadequate interface and collaboration between midwifery and child health nursing. Within the first barrier of protocol structure there were four areas that the participants highlighted. Firstly, there was the implication that if mental health promotion is not within the structures, it won't be addressed. Secondly, the ObstetriX database hindered mental health promotion due to insufficient detail regarding parental and family strengths. Thirdly, a didactic approach to perinatal education and anticipatory guidance hampered engaging with parents and working with them to support their wellbeing. Fourthly, mental health promotion may have little voice if it is relegated to a one off education talk parental appointments/visits.

The second barrier within this concept was inadequate flexibility. This inadequate flexibility included the problem of constraints of structure, the inadaptability to suit consumers' timetables and being unresponsive to parental concerns. The third barrier within this concept identified participants as requiring greater provision of support mechanisms such as debriefing, multidisciplinary support and peer review in order to better promote mental health in parents. The fourth barrier within this concept of structural practice barriers highlighted the need for a nexus between midwifery and

child health nursing in order to better promote parental mental health by means of continuity. Overall, this concept is multifaceted and demonstrates some considerable inadequacies in midwifery and child health nursing practices. Moreover, in Tasmania at the time of this study, this concept highlights reasons why the participants may feel at times that mental health promotion is simply too difficult to incorporate in their roles, despite a strong desire to do so.

6.5.5 Acute care practice

This final concept, within the subtheme ‘incongruence in the models of care’ identifies the acute care structure that midwives in this study practice within as a barrier to mental health promotion. Three areas were discussed by a number of midwives: i) that the midwifery journey with the parent was very short lived as opposed to child health nurses; ii) that the acute care practice focus was very narrow and much bounded and; iii) the environment in which midwives work impacted significantly on how midwives interacted with parents. Overall, midwives commented that the acute care area limited their ability to interact with parents to promote mental health. This inability was due to the way these three areas interfered with establishing a therapeutic relationship with the parent thus diminishing their contact and ability to communicate with parents.

In the first instance one midwife commented regarding the short period of time in which parents are cared for by midwives in hospital: *in the tertiary section you really only see them x amount of times and then it's handed over 'cause there is nothing else you can do, 'cause the timeframe's up and you know they're gone*. She identified that midwifery was *sheltered* due this short time period, *'cause you don't go to their homes and see how they are really living unless you do extended midwifery service, of course, and even then you only see a snap shot of their life, a very small snap shot (22M)*. One child health nurse (previously a midwife) commented that midwives only see a small instance of a parent's experience and that it was *very narrow, and very clinically focussed*. She argued that in the acute care area, midwives are *dictated to as to what they can or cannot do and what their boundaries are (1CHN)*.

Finally, there was discussion about how the hospital's acute care environment decided how practice was structured: *if you are midwives in the birthing centre the way you interact with patients is very different to if you are in the antenatal care clinic run by doctors*. Furthermore, this midwife highlighted that the issue of risk determined her practice as *the environment very much influences the way you interact with clients and what you say to them, what you think about risk (14M)*.

This final concept, within the subtheme 'incongruence in the models of care' illustrates that the acute care structure in which midwives in this study practice is a barrier to mental health promotion. Three areas were discussed by a number of midwives: i) that the midwifery journey with the parent was very short lived as opposed to child health nurses; ii) that the acute care practice focus was very narrow and much bounded and; iii) the environment in which midwives work impacted significantly on how midwives interacted with parents. Overall, midwives commented that the acute care area limited their ability to interact with parents to promote mental health. This inability was due to the way these three areas interfered with establishing a therapeutic relationship with the parent thus diminishing their contact and ability to communicate with parents.

6.5.6 Discussion

This discussion section identifies some literature regarding workforce barriers, target platform, inadequate funding, and an incongruence within midwifery and child health nursing care. In particular, the barriers within the concept of incongruency in the care given to parents by participants reinforce studies about inadequate protocols, inflexibility, inadequate peer support structures, and incomplete collaboration between maternity and child health nursing services. However, some of these areas lack adequate examination in studies and thus are identified as needing further research.

Influences on nursing workforce supply include synergies between social, political, technological and economic trends, and organisational factors such as healthcare management models, employee satisfaction and career structures (DHHS 2001, p.80). In light of these factors, evident from the data, was an inadequate level of

midwives or child health nurses to cover the delivery of care in both services and that this was a concern in mental health promotion specifically. Both Schmied et al. (2008b) and Forster et al. (2006) highlight inadequate midwifery staffing in postnatal wards, as indicated by parents, which has the potential to undermine their care. Forster et al. (2006), in particular, describe the number of midwives needed to complete a day's care (1:5 morning, 1:6 afternoon evening and 1:8 night ratio) and note that a mother and baby (dyad) are recognised as 'one individual' (p.3). Factors such as contrary mix of staffing (non-midwifery care occurring), too high acuity of parent/baby mix, impact of staff leave (where staff are not replaced) also affected the ability of midwives to care for parents. A major theme from this study (Forster et al. 2006) was the staff distress that was related to inadequacy of staffing levels.

Overall, a significant issue highlighted by studies of care in midwifery (Forster et al. 2006; Schmied et al. 2008b) and including workforce studies (Pugh et al. 2012) was the issue of inadequate levels of midwives. There were no studies found that examined staffing levels in child health nursing. The concept of inadequate staffing arguably has the consequence of some tasks being prioritised above others in order to complete the care needed each midwifery shift. As biomedical surveillance and risk assessments have priority in both midwifery (and child health nursing), it is clear which tasks are likely to be performed and which ones – potentially mental health promotion – will be omitted.

Another workforce issue that participants highlighted was an inadequate consideration and preparation by management (and/or top-down policy and protocol developers) of how discussion of such issues as mental illness impacted upon both midwives and child health nurses delivery of care. Reiger and Lane (2012) exhort making "organisation carescapes in maternity services just and good for those who give care as well as for those who receive it" (p.5). In the current 'midwifery-scape' contemporary discourses offer 'romanticised' views of how care is delivered – such as 'with women' (Homer et al. 2009) and 'emotional care' that are unrealisable with the way midwifery is currently structured within a medically dominated hospital environment.

If issues of inadequate time and staffing levels that decrease midwifery capacities to promote mental health are not significant enough, an inability to provide ‘emotional care’ has even less chance of being implemented due to these constraints.

Furthermore, the rush to complete tasks allows little room for reflection and meta-cognition by midwives (and potentially child health nurses) of the content of what is being assessed. Significantly, there are few studies that have examined the stress of the content of midwifery and child health nursing care and its effects on individual midwives and child health nurses. There have been a number of recent studies that asked midwives (Sullivan et al. 2003; Ross-Davie et al. 2006; Yelland et al. 2006; McLachlan et al. 2011) and child health nurses (Shepherd 2011) how they raised the issue of or screened for psychosocial issues and one that measured their competence to do so (McLachlan et al. 2011). However, no studies were found that specifically asked them how discussing issues such as mental illness or intimate partner violence affected them and whether they seek support in performing assessments of these issues or debriefing afterwards.

Another incongruity of care that child health nurses identified as a barrier to their promotion of mental health was the ‘platform’ upon which their care is based.

Although many states of Australia have been grappling with the introduction of a more targeted at-risk-based platform for the past 10 years, the child health nurses of Tasmania were only commencing this journey at the time of the interviews in 2011-2012. Hence, much of the literature that is reinforced by this study’s finding is already well documented in a number of Australian studies and is supported by international research.

What is significant to acknowledge regarding this concept of target platform is that child health nursing began its service throughout Australia, and in many countries in the world, within a universal platform, meaning that access was available to all parents and children and that this service was free of charge. There were rumblings from the early 1990s regarding a shift in focus from health promotion to targeting at risk parents and children, with screening early detection assessments for illness (Boss et al. 1995; Hall 1996; Brennan 1998; Barnes & Rowe 2003). These changes were in line with the increasing influence of Selective Primary Health Care’s targeting of priority illnesses and disease, with the rationalisation of health funding at its core

(Rifkin & Walt 1986; Werner & Sanders 1997; Cuerto 2004). This targeting of screening and assessment for early detection of illnesses arguably decreased the service's ability to place emphasis on promotion. This shift from a comprehensive and promotional service to one of at risk identification and early detection continues to be felt in the service's current form. Although home visiting remains a universal program, the services that occur within are targeted and include such items already discussed in *Chapter Five* such as psychosocial assessment, support and education about parenting concerns, and determinations about which families need to receive ongoing support through sustained home visiting (Government of South Australia, 2007; New South Wales Health, 2009).

One final point made by the participants regarding the concept of a targeted platform was that they held grave concerns about an increase in emphasis on the number of universal home visits with targeted assessments and the ongoing outcomes (with the need for further visits) that the assessments would bring. In undertaking these visits, they were concerned they would not have time to meet all families' needs. These concerns are borne out in mainland Australian studies where an increase in home visiting has decreased the capacity for other going services (Kruske et al. 2006) and for supporting all families, not just those at-risk (Barnes et al. 2003). Experiences are similar overseas with parents stating that if they are not 'at-risk' they are excluded from the child health nursing services (Roche et al. 2005). In short, child health nursing has devolved to a universal home visiting service in which targeted assessments and surveillance are offered. Given that time constraints are a known factor in diminishing the promotion of mental health, it can only be surmised that targeting at-risk constraints, with their concomitant need for significant increases in staffing (Schmied et al. 2011), further weaken any possibility of mental health promotion taking place.

Another concept that concerned both midwives and child health nurses was funding and how decreased budgetary allowances for both services impacted upon how they delivered care, and in particular, how they promoted mental health to parents. The previous concept of 'target platform' explains how the effects of economic policies in the 1990s shaped the current format of targeted approaches of early detection of illness such as perinatal depression in the perinatal period. However, another reason

for inadequate funding for this vital construct lies in the measurement of outcomes of mental health promotion. For the most part being able to secure funding for mental health promotion in the first place is problematic.

There are a number of studies whose aims are to exhort an economic case for mental health promotion (e.g. Moodie & Jenkins 2005; Friedli & Parsonage 2007; McDaid 2008; McDaid & A-la Park 2011). Initially, studies advocating mental health promotion discuss how mental health promotion is associated with better health outcomes though such improvements in “self-esteem, confidence, self-esteem, hopefulness and social integration” (Friedli & Parsonage 2007, p.15) against a background of burden of mental illness (McDaid & A-la Park 2011). These studies then turn to the problematic issue of quantifying how mental health promotion actually occurs and why funding this construct has its detractors. The main constraints to gaining funding include an inability “to capture the indirect benefits of improved mental health in evaluation studies” through reasons of “coverage, measurement and attribution” (Friedli & Parsonage 2007, p.15). Furthermore, outcomes can take many years to eventuate and are subject to many influences and interpretations.

Nevertheless, participants in this study maintained that budgetary constraints detract from the mental health promotion they desire to give to parents. Moreover, they appear to feel isolated in their care of parents by inadequate funding due to a perceived lack of control over the way their delivery of care is organised. The ‘beancounters’(CHN25) are distant figures who participants feel have little understanding of what they are trying to achieve. This remoteness is only exaggerated when they are directed to perform assessments that detract from ‘being with women’, discussing ‘off the topic conversations’ during breastfeeding, or encouraging parents to discuss ‘their hopes and dreams for their children’.

The penultimate concept that participants identified included a number of structural barriers within practice. The first of these related to the perceived need to have mental health promotion as part of the care structure that midwives and child health nurses give to parents. In order to achieve this, the construct would need to be incorporated in day-to- day conversations with parents through the tools and

assessments they perform. There was no research found where mental health promotion was specifically identified in midwifery. In child health nursing, literature on strength-based assessments detail within assessments how this promotion can enhanced (Smith & Ford 2013). A second structural barrier of inadequate flexibility within the services concerned child health nurses, mainly relating to funding constraints such as being able to visit parents when asked to by them. This inflexibility highlights what Alford (1975) identified as not heeding or potentially repressing patients' – in this study's case, parents' – interests in engaging in and controlling their healthcare (Herzlinger 2004). In the participants' examples, the care that parents received was dictated by the health service and was not parent-initiated nor oriented.

A third structural barrier within practice identified was inadequate peer support and multidisciplinary meetings amongst midwives and child health nurses, and amongst other people who care for parents. In particular, participants stated that funding constraints and inadequate recognition of the importance of discussion time (case studies and sound boarding ideas) with peers were barriers to being able to promote mental health well. One UK study focussed on examining the culture of midwifery and found that midwives are not good at supporting each other (Kirkham 1999). However, this inability to support peers is described by Roberts (1983) as pertaining more to midwives being part of an "oppressed group" (p. 24) through medical dominance in the hospital system, and thus too oppressed to take part in supporting others. Presently, there are still few studies that examine how midwives support each other in the promotion of mental health in parents, or as participants more commonly contended, in perinatal depression prevention. There were no studies found in child health nursing literature regarding peer support that increased mental health promotion in parents. Furthermore, there were few studies that identified multidisciplinary meetings as vital in the promotion of parental wellbeing, although one study maintained that child health nurses working together with social workers could support child wellbeing (Fagerskiold & Wahlberg 2000).

A number of participants highlighted an inadequate interface and collaboration between midwifery and child health nursing in their responses. This issue as a workplace structural barrier reinforces a number of studies that highlight

collaboration between the two services as in need of greater discussion and implementation. The principles of collaboration appear in the standards for Australian registration of both midwives and child health nurses (AHPRA 2012) and are frequently espoused in policies (Schmied et al. 2011). However, there are few reported models of service collaboration between maternity and child health services within Australia (Schmied et al. 2010) due to a lack of research that examines increased health outcomes for families (Rodriguez & des Rivieres-Pigeon 2007).

The final area of incongruency for mental health promotion identified by participants included the acute care practices of midwifery. That a ‘women-centred’, Primary Health Care framework-based practice was situated within an acute care hospital appeared to be anathema to a number of participants – particularly where an acute care environment did not allow for their promotion of mental health in parents.

Many of the barriers to mental health promotion within acute care practices have already been highlighted throughout this chapter as they pertain to the environment in which the midwives worked. These barriers included time, staffing and funding constraints, a decreased ability to communicate with parents and build a trust-relationship, an overload of paperwork, surveillance practices and assessments of risk, with an emphasis placed on the “contradictions in practices, such as trying to be flexible in the care provided and at the same time having to follow protocols and guidelines”(Schmied et al. 2008, p.102). Furthermore, midwives have reported less individualised care, particularly given “the checking, education and documentation required during what are increasingly short hospital stays” (McLachlan et al. 2011, p.724).

6.5.7 Summary of subtheme regarding an incongruence of models of care as a barrier to mental health promotion

Incongruence within the two services’ models of care in this study acted as a significant barrier to mental health promotion. There were five concepts within this subtheme that underpinned this incongruence: i) workforce barriers, ii) target platform for child health nursing, iii) inadequate funding, iv) structural practice barriers, and v) acute care practices. The first concept of workforce barriers

highlighted that inadequate access to required services due to workforce constraints and discharge from hospital imperatives are serious limitations. Workforce barriers also included how mental health promotion is a possible topic of anguish and concern for some midwives and child health nurses and raised the question whether in-servicing education about mental health promotion in the two services needed to better acknowledge this issue. The second concept of incongruity in care indicated that a selective, target platform of vulnerability for child health nursing would obstruct their ability to ensure that all parents received anticipatory guidance. The child health nurses were also concerned in the first instance how 'vulnerability' was categorised and how some parents would miss out if not found to be within this category.

The third concept of incongruity in care related to the concern held by some participants that inadequate funding was a threat to promoting mental health in parents. In particular, participants were highly critical of the decisions by budget centres about where the emphasis in funding was placed. Of most concern was the juxtaposing of a universal child health service and a highly specialist, indicative child protection service. The fourth concept of incongruity in care detailed structural practice barriers and included how the structuring of protocols impacted upon whether mental health promotion occurred or not. Structural practice barriers also included the ObstetriX database with its limited detail about family strengths, and a didactic approach to perinatal education and anticipatory guidance as hampering mental health promotion. This fourth concept of structural practice barriers also highlighted how 'one off' education talks gave mental health promotion little voice as a construct when it was consistently embedded in education throughout the perinatal period. The fifth and final concept of incongruity in care emphasised how the midwifery journey with the parent was very short lived and that the acute care practice focus was very narrow. This concept of structural practice barriers also illustrated how the busy ward environment in which midwives work impacted significantly on how midwives interacted with parents. This busy ward environment implies unsuitability for establishing a therapeutic relationship that ultimately supports the promotion of mental health.

6.6 Conclusion

The first findings/discussion chapter entitled '*Much ado about nothing?*' highlighted the '*what*' of terminology usage and how it possibly impacted on parental mental health promotion provided by the participants of this study. The second findings/discussion chapter entitled '*The elephant in the boa constrictor*' presented the '*how*' of participant practices that were analysed in both interviews and documents to reveal strong, risk oriented assessment examples that incorporated mostly screening and early detection of perinatal depression as opposed to strengths-based approaches.

This third and final findings/discussion chapter has established a number of significant barriers to mental health promotion for midwives and child health nurses in Tasmania in early parenting. In particular, it has highlighted four overarching subthemes of communication barriers, time barriers, medical influence and incongruence within the two services' models of care. Within most subthemes were numerous concepts that detailed barriers to building therapeutic relationships and communicating with parents, together with workforce barriers, inappropriate target platforms, inadequate funding, considerable structural practice barriers and problematic acute care practices.

At the beginning of this third and final findings/discussion chapter I raised the question whether midwives and child health nurses were complicit in continuing an approach to mental health promotion within their two services that clearly addressed detection of and early intervention in the development of perinatal depression. This was as opposed to pursuing strengths-based education and support that promotes the "capacity that already exists" (Pollett 2007, p.1) in parents. I posit that there is some small culpability within individual midwives/child health nurses, or more probably within midwifery and child health nursing teams of early parenting support, in not promoting mental health – an inability to 'resist domestication' (Thomas 1993, p.1). Certainly, the data implies that a greater understanding and exploration of the Ottawa Charter and strengths-based assessments could be in order. However, and it is a significant 'however', this chapter has established a number of substantial barriers to mental health promotion for midwives and child health nurses in early parenting. It

has highlighted the structural barriers within the services themselves, and those that have been imposed upon the services. Furthermore, these numerous impediments to mental health promotion clearly demonstrate why ‘things can get too hard’ for both midwives and child health nurses and why their practice of promoting mental health (as they currently understand it to be) in parents is nearly impossible, despite their fervent desire to do so.

The next chapter is the final chapter of thesis, in which I offer an overview of the study and its findings. Within this concluding chapter entitled ‘*Serving the interests of parents in mental health promotion*’, I also include a number of recommendations for future research and for the two Tasmanian early parenting services that have been the focus of this study.

Chapter 7

Serving the interests of parents in mental health promotion?

7.1 Conclusion

“As for the future, your task is not to foresee it, but to enable it.”

(de Saint-Exupéry 1948)

My prior clinical work experiences in hospital midwifery and community family and child health nursing informed me that mental health promotion was potentially not afforded a ‘voice’ in perinatal education within these two services. I wanted to address this perceived marginalisation and provide evidence to potentially transform the practice of promotion that parents received of this valuable construct.

The aim of this critical ethnographic study was, therefore, to critically analyse mental health promotion in midwifery and child health nursing-led education. This aim was substantiated upon a gap in global evidence regarding how mental health promotion, as opposed to early detection or illness prevention, was understood and implemented in perinatal education. The significance of the study lay in four main areas: the burden of perinatal depression for parents, children, families, communities and the wider society; the manifold benefits of staying mentally well throughout the perinatal period and beyond; the benefits of a strengths-based orientation; and the role of neural pathway development in infancy and childhood.

This study utilised the context of Tasmanian, hospital-based midwives, and child health nurses who worked in the Tasmanian community setting. Overall, 31 of these key providers of perinatal education were interviewed (13 midwives and 18 child health nurses) for their understandings and practice of mental health promotion. Document analysis for mental health promotional content of policy, protocols and education curricula from these two services was also conducted.

Through interviewing and document analysis, this study found a number of perceived barriers to promoting mental health within the midwifery and child health nursing services. As a secondary finding, this study highlights that early detection and prevention of perinatal depression were commendably foremost in both services. However, this study concludes that the interests of parents in receiving mental health promotion were not served in midwifery and child health nursing-led perinatal educational practices in Tasmania due to a substantial number of service barriers.

7.1.1 *Summary of findings*

Three key findings were interpreted and developed through my critical lens as teacher, midwife, child health nurse and nursing academic: 1) mental health promotion was complex to understand and to implement, 2) mental health promotion was represented in perinatal educational practice as early detection and prevention of perinatal depression, and 3) there was a plethora of constraints within the Women's and Children's Services (WACS) and Child Health and Parenting Service (CHAPS) that made detecting and preventing perinatal depression difficult and promoting mental health almost impossible.

In the following paragraphs I present brief summaries of these findings together with recommendations for the two services and for future research. In particular, it is important to acknowledge that the recommendations for the two services are an integral part of my critical ethnographic approach that behooves me to indicate how this study will seek to transform the practice of mental health promotion in perinatal education. These recommendations will form the basis of a report that will be presented to both services, as requested by the directors of each service in the initial stages of this study.

Defining mental health

The study highlighted that 'mental health' was a consternating and confronting term that appeared not to be at the forefront of the participants' practice discourse. This confusion in terms is an important finding as it problematises why understandings of mental health still remain cognitively dissonant for midwives and child health nurses.

Service recommendation: that the terms ‘mental health’ and ‘mental health promotion’ be discussed between midwives and between child health nurses and that a consensus terminology they decide upon to indicate perinatal depression and mental health promotion be synthesised within practice documents. Furthermore, that in-servicing about this adoption of consensus of terminology occurs.

Complexity of mental health in practice

The study highlighted that the complexity of mental health in practice resulted in three concepts of screening, raising awareness of deviations from the norm, and raising awareness of mental illness. These three concepts were representative of the understandings of midwives and child health nurses regarding mental health promotion in practice. I argued that it was possible that both midwives and child health nurses had appropriated the terminology from the National Perinatal Depression Initiative guidelines as their framework.

Service recommendation: that mental health promotional frameworks such as those of Jahoda, Antonovsky, and Bronfenbrenner (and others) be discussed and adopted within policies of the two services with the aim that daily protocols gain a wider incorporation of these framework components.

Service recommendation: that a further revision of assessments used by midwives and child health nurses be performed to include a strengths-based assessment process as the basis of each assessment where appropriate.

Explaining the complexity in mental health

This study highlighted that explaining mental health to parents was difficult for midwives and child health nurses due to reasons of societal and self-stigmatisation, and the perception of mental health promotion globally as being overwhelming.

Service recommendation: that the issue of stigma be discussed as an in-service topic with both services with the outcome of de-stigmatising the use of mental health promotion, at least amongst midwives and child health nurses.

Research recommendation: exploratory study of how stigma influences a discussion with parents of perinatal depression signs and symptoms.

Participant practice embedded in a perinatal depression framework

RISK FACTORS

This study found a risk orientation in perinatal education practice by both services, particularly in raising awareness of risk in parents.

Service recommendation: 1) that a greater understanding and acknowledgement of both protective factors (albeit part of a risk-based framework) and a promotion of the strengths parents already bring to early parenting be captured by midwives and child health nurses, and 2) that a greater number of protective factors and strengths be incorporated within protocols of both services.

(MENTAL) HEALTH PROMOTION

This study found that health promotion was understood to be about health education and wellness or prevention categories such as ‘nutrition and exercising’ and that mental health promotion was about the early detection and prevention of perinatal depression, i.e. that placing the word ‘mental’ in front of health promotion did not influence a ‘positive’ view of health education around socialising, autonomy or resilience.

Service recommendation: 1) that a discussion take place at ward and clinic levels regarding the differences between health promotion, health education and mental health promotion with further in-servicing where needed.

KNOWLEDGE CONSTRUCTION OF MENTAL HEALTH PROMOTION

This study argued that midwifery and child health nursing knowledge construction of mental health promotion revealed how midwives and child health nurses constructed their understanding of mental health promotion and how this construction potentially impacted upon their practice and, in turn, parents. This study also found that this understanding of mental health promotion was influenced by university education, professional in-servicing, working with parents and their own personal experiences outside of the work context.

Service recommendation: that a discussion take place with university providers of midwifery and child health nursing, in-servicing educators and curriculum developers of the two services regarding the incorporation of mental health promotional content in addition to perinatal depression awareness, early detection and prevention.

WORKPLACE STRUCTURE

This study found little evidence of mental health promotion in workplace structures. However, midwifery participants described how the services of a mental health nurse would support them in working with parents who were detected as having a mental illness. Furthermore, midwives suggested that in-servicing on mental health promotion (to them, perinatal depression awareness) needed to occur on a regular basis as part of mandatory training.

Service recommendation: 1) that both services employ a mental health liaison nurse to support both midwives and child health nurses in debriefing about parental illnesses, and to be part of the referral process for parents when perinatal depression or other mental illnesses has been detected on the ward or at the clinic, and 2) that in-servicing or professional development on the signs and symptoms of perinatal depression (and any further research evidence updates on early detection, prevention and treatment) occur on a regular basis – suggested by participants as being at least yearly.

Policies and protocols embedded in a mental illness framework

ANTICIPATORY GUIDANCE

This study found that anticipatory guidance within midwifery and child health nursing followed an illness orientation. Anticipatory guidance in both midwifery and child health nursing documents was also found to be inconclusive regarding mental health promotion due to inadequate content description.

Service recommendation: that all protocols within both services have guiding descriptions using strengths-based terminology incorporated for use in anticipatory guidance.

FAMILY/PSYCHOSOCIAL ASSESSMENTS

This study found little evidence to suggest that mental health promotion occurred within these assessments. The service recommendation for this concept is in accordance with the one for anticipatory guidance (above).

EDINBURGH POSTNATAL DEPRESSION SCALE (EPDS)

This study found that although many participants discussed being able to talk with parents about feelings of anxiety and perinatal depression that might have been revealed from the scale, there was little evidence that participants used the first two questions about happiness and enjoyment as springboards to a greater discussion about such qualities in parenting.

Service recommendation: that a discussion at ward and clinic level be instigated around how the first two questions of the EPDS can be used with parents to highlight these two qualities (and others) as a beginning to a conversation on strengths.

PERINATAL DEPRESSION RESOURCES

This study found that the use of adjunct resources on the ward and in clinics revolved around perinatal depression awareness.

Service recommendations: that the brochures provided by the Child Health Association Tasmania (CHAT) be used to a greater extent by midwives and child health nurses in explaining *how* the activities they provide support mental health promotion.

OBSTETRIX

This study found that the ObstetriX midwifery database was a barrier to mental health promotion due to its emphasis on mental illness and lack of provision for the promotion of current and future parenting capacity.

Service recommendation: that a discussion with developers of the database take place in order to facilitate an incorporation of a history of parental strengths.

CHILD HEALTH SURVEILLANCE

This study found that there was little evidence of any form of mental health promotion delivered within the 'blue book' other than the information provided by the Child Health Association of Tasmania.

Service recommendation: that the risk-discourse orientation be redeveloped into strengths-based, with an acknowledgement of the Child Health Association Tasmania's activities throughout the document to enhance greater community participation and control.

ANTENATAL PARENTING CLASSES

This study found that although the majority of content within the antenatal classes' outlines and lesson plans focus on labour, there is a clear inclusion of material related to increasing confidence in parenting and to exploring how to strengthen the parenting experience overall.

Service recommendation: that a stronger promotional framework with an evidence base be developed that brings together all the 'mechanisms' of mental health promotion for greater inclusion of this valuable construct.

Research recommendation: to investigate mental health promotional frameworks, such as Antonovsky's (1979;1987) Salutogenic Model and Sense of Coherence concept, that could be applied in perinatal education.

Inadequate communication

BARRIERS TO THERAPEUTIC RELATIONSHIP BUILDING

This study argued that mental health promotion is largely dependent upon the relationship that exists between midwives and child health nurses and parents and that without the prioritisation of this process within the two services, effective mental health promotion cannot take place. This finding also emphasises the importance of mental health promotion as indicative of client-centred care, currently advocated by many organisations such as the Australian Commission on Safety and Quality in Health Care (ACSQHS).

Service recommendation: that time to build relationships with parents be recognised within policy of both services and incorporated in protocol design.

BARRIERS TO COMMUNICATING WITH PARENTS

This study found that barriers to communicating with parents included the emphasis on completing paperwork and entering data on ObstetriX, inadequate education about how to communicate with parents, and inadequate privacy for midwives and parents.

Service recommendation: 1) That the way in which parental data is recorded be examined for better ways of engaging with parents, as opposed to writing or entering data whilst parents are speaking, and 2) that all forms of record entry (assessments and protocols) be examined for agency initiated questioning (agenda) in order to increase a parent-driven agenda in the two services.

Research recommendation: that a study of how communication is incorporated within tertiary midwifery and child health nursing courses, professional development and in-servicing be undertaken.

Research recommendation: that a study that examines privacy for parents within midwifery units be undertaken.

Inadequate time

This study found that inadequate time impeded the performance of assessments, the initiation of protocols, and the inclusion of programs such as first time parent groups and thus hindered potential mental health promotion.

Research recommendation: 1) that a study into how time is allocated within these services for the different assessments and protocols with a cross comparison to other states and international studies be undertaken, and 2) that this study also examine how this allocation compares with the actual implementation.

Medical influence

This study found that the influences of medical dominance and a biomedical framework have had a potentially, detrimental impact on mental health promotion in the midwifery and child health nursing practices.

Service recommendation: that the first small step is taken to examine surveillance practices within each service for where mental health promotion can be incorporated. This is until such time that medical dominance practices are ‘decommissioned’ in favour of *bio/socio ecological and* strengths-based frameworks.

Research recommendation: 1) that international studies (including non-English this time) be examined for non-medical dominant midwifery and child health nursing strengths-based frameworks, and 2) that this type of framework be developed if no studies are found.

Incongruent delivery of care

WORKFORCE BARRIERS

This study found that delivery of care to parents by both midwives and child health nurses was affected by 1) potential inadequate levels of staffing and 2) an inadequate acknowledgement of how discussing mental illness with parents affects those who do so.

Service recommendation: that the right of access by parents to both services be discussed amongst policy developers and the implications of not doing so be incorporated in service risk-mitigation processes.

Service recommendation: that the practices within the teenage cu@home programme, in particular how they pertain to therapeutic engagement and relationship building over the antenatal and early parenting periods, be widened to encompass the entire service delivery.

Research recommendation: that further research be conducted investigating 1) how assessing for mental illness and discussions of perinatal depression affect midwives and child health nurses and in turn, the care provided by them, and 2) formal and

informal debriefing processes for midwives and child health nurses where these situations arise.

TARGET PLATFORM

This study argued that the delivery of care to parents by child health nurses is affected by which platform (e.g. universal, selective) the service is based upon. This study found that the issue of ‘vulnerability’ was potentially problematised by policy makers and that this caused confusion and concern amongst the child health nurses.

Research recommendation: that further investigation be undertaken in Tasmania, in 12 months’ time, to see how the new risk-oriented service has addressed the service’s current claimed universal delivery of and access to care.

INADEQUATE FUNDING

This study found that the way the two services were funded affected the delivery of care that parents received. In particular, participants were highly critical of the decisions by budget centres about where the emphasis in funding was placed.

Service recommendation: that mental health promotion be recognised as an important inclusion into the two services and that appropriate funding be apportioned to support this inclusion.

Research recommendation: that a study 1) determine how funding appropriation for these two services is decided in relation to factors that include political and socio-economic determinants, and 2) that this study examine how a universal child health service is juxtaposed in the same overarching service in Tasmania as a child protection service, youth justice and intimate partner violence counselling and support i.e. because they support families regardless that their remits are categorically diverse – is this the optimum division of services and whose interests does this division serve?

WORKPLACE STRUCTURAL BARRIERS

This study found that the structuring of protocols of both services, inadequate flexibility, inadequate peer support, and inadequate interface and collaboration

between midwifery and child health nursing were considerable workplace structural barriers to promoting mental health in parents.

Service recommendation: that mental health promotion through a strengths-based approach be incorporated across all protocols within both services in order that the construct be addressed by midwives and child health nurses when working with parents.

Research recommendation: that further research be undertaken (secondary to this study) that investigates what parents consider ‘creates (mental) health’. In doing so it would be an aim of the study to engage in constructing parent-led mental health promotion within these two services.

Research recommendation: that a study investigates the midwifery and child health nursing needs of parents in the perinatal period and compares how the two services currently understand and respond to these needs.

Research recommendation: that a study investigate 1) how midwives and child health nurses encourage and support discussion of parental case studies of each other on the wards and clinics, respectively, 2) how the two services support midwives and child health nurses to do so, and 3) which allied health formal support structures are in place to supplement these discussions, e.g. psychologists, mental health nurses.

Research recommendation: that a study 1) investigate the nexus of care (and communication of that care) between both services in Tasmania, 2) in particular where and how mental health promotion connects the two.

ACUTE CARE PRACTICES

This study argued that the acute care structure in which midwives practice is a potential barrier to mental health promotion. In particular, midwives stated that the midwifery journey with the parent was very short lived as opposed to child health nurses, that the acute care practice focus was very narrow and much bounded, and the environment in which midwives work impacted significantly on how they interacted with parents. An inability to interact with parents was due to the way these three areas interfered with establishing a therapeutic relationship with the parent thus

diminishing their contact and ability to communicate with parents. Barriers to mental health promotion within acute care practices have already been addressed in the recommendations above, as they pertain to the environment in which the midwives worked. These recommendations address time, staffing and funding constraints, a decreased ability to communicate with parents and build a trust-relationship, an overload of paperwork, surveillance practices and assessments of risk.

Further recommendations that lie beyond the data, but are related to many of the findings include a discussion on nursing education – what nurses are taught, their framework and orientation to practice, how their perspective on nursing changes once they enter the workplace, the disconnect or connect between education and practice. Certainly, nursing education needs to consider how nurses should be influencing policy and what it would require to prepare nurses to get them at the policy making table.

In summary, mental health promotion appeared not to be central to policy decisions within the Womens and Childrens Services and Child Health and Parenting Service in Tasmania. Furthermore, although the DHHS policies claimed that midwives and child health nurses work within a Primary Health Care framework and that their services are health promotion-based, these claims are a form of potential political rhetoric (Jane-Llopis, 2005). The challenge now is to move beyond this political rhetoric (Sainsbury 2000). These findings behoove an assurance by policy makers that the ‘injustice’ of marginalising such an important construct – *of inspiring and supporting parental emotional and spiritual resilience and a belief in parents’ worth; supporting parents’ abilities to think, perceive, interpret, manage life, communicate, initiate, develop and sustain mutually satisfying relationships; and support parental autonomy by increasing their health literacy* – is addressed, and soon.

7.2 Dusting of snow at the very top of the mountains

There is a considerable ‘mountain’ of literature regarding the constructs of health promotion and mental health promotion, with evidence of mental health promotion implementation gaining ascendancy globally in recent years. There is also a substantial ‘mountain’ of literature now regarding the burden of perinatal depression

and its signs and symptoms, and treatment after early detection. Astride both mountains lies an abundance of snow of research that makes it incumbent upon midwives and child health nurses to consider how important the benefits are of supporting a family to stay well in the first instance – in particular, the benefits of parents staying mentally well to support neurodevelopment within the early years of a child's life.

However, there are few studies that seek to establish how midwives and child health nurses incorporate these benefits into their work practices or how the services in which they work support them to do so. This study has aimed to add a small dusting of snow at the very top of these mountains of research by critically analysing how 31 midwives and child health nurses understand and practice mental health promotion in Tasmania. McMurray (2011) exhorts all nurses (and midwives) to expand their horizons further than current practice and to be part of a process 'between health and place', thus engendering the tenets of Primary Health Care. In this study, it has become clear that many obstacles lie in the path of child health nurses and midwives to engage with parents more closely in the first instance and that being 'between health and place' and supporting parents to flourish, will require substantial change to policies and protocols of practice in Tasmania. It has been the aim of this study, a small addition of snow on some very large mountains, to begin this process.

Chapter 8

References

- Alford, RR 1975, *Health care politics, ideological and interest group barriers to reform*, Chicago, IL: Chicago University Press.
- Altheide, D 1987, 'Ethnographic content analysis', *Qualitative Sociology*, vol. 10, no.1, pp.65-77.
- Antonovsky, A 1979, *Health, stress and coping*, Jossey-Bass, San Francisco.
- Antonovsky, A 1987, *Unravelling the mystery of health*, Jossey-Bass, San Francisco.
- Affonso, D, Lovett, S, Paul, S, et al. 1991, 'Predictors of depression symptoms during pregnancy and postpartum', *Journal of Psychosomatic Obstetrics and Gynaecology*, supplementary, vol.12, pp.255–271.
- Ahldén, L, Goransson, A, Josefsson, A & Alehagen, S 2008, 'Parenthood education in Swedish antenatal care: Perceptions of midwives and obstetricians in charge', *The Journal of Perinatal Education*, vol.17, no.2, pp.21-27.
- Ahldén, I, Ahlehagen, S, Dahlgren, LO & Josefsson, A 2012, 'Parents' Expectations About Participating in Antenatal Parenthood Education Classes', *J Perinat Educ*, Winter, vol.21, no.1, pp.11–17.
- AIHW 2006, 'Health expenditure Australia 2004-05', *Australian Institute of Health and Welfare*.
- AIHW 2012, *Perinatal depression: data from the 2010 Australian National Infant Feeding Survey*, Cat. no. PHE 161, Canberra
- Annor, S & Allen, P 2009, 'Why is it difficult to promote public mental health? A study of policy implementation at local level', *Journal of Public Mental Health*, vol.7, no.4, pp.17-28.

Armstrong, S & Small, R 2007, 'Screening for postnatal depression: not a simple task', *Australian and New Zealand Journal of Public Health*, vol. 31 no. 1, pp.57-61.

Arnstein, S 1969, 'A ladder of citizen participation', *American Institute of Planners*, vol.35, no.4.

Atkinson, PA, & Coffey, A 1997, Analysing documentary realities, In D. Silverman (Ed.), *Qualitative research: Theory, method and practice*, London: Sage, pp.45–62.

Atkinson, PA, & Coffey, A 2004, Analysing documentary realities, In D. Silverman (Ed.), *Qualitative research: Theory, method and practice* (2nd ed.), London: Sage, pp.56–75.

Australian Health Practitioner Regulation Agency (AHPRA) 2012.

Australian Bureau of Statistics (ABS) 2010.

Australian Bureau of Statistics (ABS) 2014.

Babcock, BA 1980, 'Reflexivity: definitions and discriminations', *Semiotica*, vol.30, no.1/2, pp.1–14.

Bandura, A 1977, 'Self-efficacy: toward a unifying theory of behavioral change', *Psychol Rev*, Mar, 84(2),191-215.

Barclay, L, Everitt, L, Rogan, F, Schmied, V & Wyllie, A 1997, 'Becoming a mother – An analysis of women's experiences of early motherhood', *Journal of Advanced Nursing*, vol.25, no.4, pp.719–728.

Barnes, M, Courtney, M, Pratt, J & Walsh, A 2003, Contemporary child health and nursing practice: services provided and challenges faced in metropolitan and outer Brisbane areas, *Collegian*, vol.10, no.4, pp.14-19.

Barnes, M & Rowe, J 2013, *Child, youth and family health: strengthening communities*, Australia, Elsevier.

Barry, M 2001, 'Promoting positive mental health: theoretical frameworks for practice', *International Journal of Mental Health Promotion*, vol.3, no.1, pp.26-34.

Barry, M & Jenkins 2005, *Implementing mental health promotion*, Sydney, Elsevier.

Barry, M 2007, Researching the implementation of community mental health promotion programs, *Health Promotion Journal of Australia*, vol.18, no.3, pp.240-246.

Battams, S 2009, 'Mental health promotion, Australian policy, and housing for people with mental illness, *Australian e-journal for the advancement of mental health*, vol.8, no.2.

Baumbusch, JL 2011, 'Conducting critical ethnography in long-term residential care: experiences of a novice researcher in the field', *Journal of Advanced Nursing*, vol. 67, no.1, pp.184–192.

Beake S, McCourt C, Bick D 2005, 'Women's views of hospital and community-based postnatal care: the good, the bad and the indifferent', *Evidence Based Midwifery*, vol.3, no.2, pp.80—6.

Beck, CT 1999, Postpartum depression: Stopping the thief that steals motherhood, *AWHONN Lifelines*, Aug-Sept vol.3, no.4, pp.41-4.

Benner, P 1984, *From Novice to Expert: Excellence and Power in Clinical Nursing Practice*, Addison-Wesley, Menlo Park, CA.

Bernard-Bonnin, AC 2004, Canadian Paediatric Society Mental Health and Developmental Disabilities Committee, *Paediatr Child Health*, vol.9, no.8, pp.575-83.

Beyondblue 2008, *Beyondblue National Action Plan for Perinatal Mental Health 2008-2010*: Full Report.

Bjerkeli LG & Grimsmo, A 2006, 'Parent-held child health records do not improve care: A randomized controlled trial in Norway', *Scandinavian Journal of Primary Health Care*, vol.24, no.3, pp.186-190.

Boath, E, Bradley, E, & Henshaw, C2005 The prevention of postnatal depression: A narrative systematic review, *Journal of psychosomatic obstetrics and gynaecology*, vol.26, no.3, pp.185-192.

Bornstein, MH 2002, *Parenting infants: Handbook of Parenting*, (2nd Ed), Mahwah, NJ, Lawrence Erlbaum Associates.

Bourdieu, P 1991, *Language and symbolic power*, Cambridge, MA, Harvard University Press.

Boss, P, Edwards S & Pitman, S 1995, *Profile of Young Australians*, Churchill Livingstone, Melbourne.

Bowen, GA 2009, 'Document Analysis as a Qualitative Research Method', *Qualitative Research Journal*, vol. 9, no. 2, pp. 27-40.

Bowers, BJ, Luring, C & Jacobson, N 2001, 'How nurses manage time and work in long-term care', *Journal of Advanced Nursing*, vol.33, no.4, pp.484-491.

Braun, V & Clarke, V 2006, 'Using thematic analysis in psychology', *Qualitative Research in Psychology*, vol.3, no.2. pp.77-101.

Bremberg, S 2006, *New tools for parents, Proposal for new forms of parent support*, Stockholm, Swedish National Institute of Public Health.

Brennan, S 1998, 'Nursing and motherhood constructions: implications for practice', *Nursing Inquiry*, vol.5, pp.11-17.

Brennan, S 2007, *The Fence on the Precipice: Child Welfare Nursing 1918 –1930*, School of Nursing and Midwifery, University of Tasmania, Launceston.

Briggs, C 2006-7, 'Nursing practice in community child health: developing the nurse-client relationship', *Contemporary Nurse*, vol.23, no.2, Dec–Jan, pp.306-7.

Bronfenbrenner, U 2005, *Making human beings human: biological perspectives on human development*, Thousand Oaks, California, Sage.

Brown, S, & Lumley, J 1994, Satisfaction with care in labor and birth: A survey of 790 women, *Birth*, vol. 21, no.1, pp.4-13.

Brown & Dobran 2004

Bryanton, J, Beck, CT, Montelpare, W 2013, 'Postnatal parental education for optimizing infant general health and parent-infant relationships', *Cochrane Database of Systematic Reviews*, Issue 11.

Bryman, A 2008, *Social Research Methods*, Oxford: Oxford University Press.

Buchanan, DA 2006, 'Moral reasoning as a model for health promotion', *Social Science & Medicine*, vol.63, pp.2715–2726.

Buist, A & Bilszta, J 2006, *The beyondblue National Postnatal Screening Program, Prevention and Early Intervention 2001–2005, Final Report*, Vol 1: National Screening Program, Melbourne: beyondblue: the national depression initiative.

Caelli, K, Downie, J & Caelli, T 2003, 'Towards a decision support system for health promotion in nursing', *Journal of Advanced Nursing*, vol.43, pp.170–180.

Cahill, J 1996, 'Patient participation: a concept analysis', *Journal of Advanced Nursing*, vol.24, pp.561–571.

Calloway, 2007, Mental health promotion: is nursing dropping the ball? *Journal of Professional Nursing*, vol. 23, no 2 (March–April), pp 105–109.

Calnan, M & Rowe, R 2004, *Trust in health care: an agenda for future research*, London: The Nuffield Trust, 2004.

Canadian Child Care Federation (CCCCF) 2001, 'What We Know About the Brain, Ottawa, Canadian Institute of Child Health', *Psychiatry*, vol.42, no.1, pp.66–73.

Carise, 2009, 'Results of a State-Wide Evaluation of "Paperwork Burden" in Addiction Treatment', *J Subst Abuse Treat*, July, vol.37, no.1, pp.101–109.

Carper 1979, Fundamentals of knowing', *Advances in Nursing Science*, October, vol.1, no.1, pp. 13-24.

- Carspecken, PF 1996, *Critical ethnography in educational research: A theoretical and practical guide*. New York: Routledge.
- Casey, D 2007, 'Nurses' perceptions, understanding and experiences of health promotion', *Journal of Clinical Nursing*, vol.16, pp.1039–1049.
- Cassidy, J & Shaver, PR (Eds.) 1999, *Handbook of attachment: Theory, research, and clinical applications*, New York, Guilford Press.
- Chiariello, M & Orvaschel, H 1995, 'Patterns of parent-child communication: relationship to depression', *Clinical Psychology Review*, vol. 15, no. 5, pp. 395-407.
- Child Health and Parenting Service (CHAPS) 2010, *Personal Health Record*, Department of Health and Human Services, Tasmania.
- Child Health Association Tasmania online (chatas), www.chatas.org.au, accessed 2014.
- Clendon, J 2009, '*Motherhood and the 'Plunket Book': A social history*', PhD thesis, Auckland, NZ, Massey University.
- Cliff, D & Deery, R 1997, 'Too much like school: class, age, marital status and attendance/nonattendance at antenatal classes', *Midwifery*, vol.12, pp.139–145.
- Coburn, D 1992, 'Freidson then and now: an 'internalist' critique of Freidson's past and present views of the medical profession', *International Journal of Health Services*, vol.22, no.3, pp.497-512.
- Coffey, A & Atkinson, P 1996, *Making Sense of Qualitative Data: Complementary Strategies*, Thousand Oaks CA, Sage.
- Colwill, J 1998, 'Professionalism and control in health services provision: some lessons from the health service in Britain', *Journal of Contemporary Health*, vol.7, pp.71-6.
- Congdon, JG & Magilvy, JK 1995, 'The Changing Spirit of Rural Community Nursing: Documentation Burden', *Public Health Nursing*, vol.12, no.1, pp.18–24.

Cook, KE 2005, 'Using Critical Ethnography to Explore Issues in Health Promotion', *Qualitative Health Research*, vol. 15, no.1, pp.129-138.

Commonwealth Department of Health and Aged Care 2000, *National Action Plan for Promotion, Prevention and Early Intervention for Mental Health*, Mental Health and Special Programs Branch, Commonwealth Department of Health and Aged Care, Canberra.

Copeland, ME 2000, *Wellness Recovery Action Plan*, Peach Press, West Dummerston VT.

Corey, LM 2010, 'The Next Steps in the Promotion and Protection of Positive Mental Health', *Canadian Journal of Nursing Research*, vol.42, no.3, pp. 17-28.

Corkill, A 1995, 'Effectiveness of current antenatal care', *British Journal of Midwifery*, vol.3, no.10, pp.528-532.

Corolan, M & Hodnett, E 2007, 'With woman' philosophy: examining the evidence, answering the questions', *Nursing Inquiry*, vol.14, no.2, pp.140–152.

Corrigan, PW 2004, 'How Stigma Interferes With Mental Health Care', *American Psychologist*, vol.59, no.7, pp.614-625.

Cowley, S and Houston, A 2003, 'A structured health needs assessment tool: acceptability and effectiveness for health visiting', *Journal of Advanced Nursing*, vol.43, no.1, pp.82–92.

Cox, JL, Holden, JM, Sagovsky, R 1987, 'Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale', *Br J Psychiatry*, vol.150, pp.782-786.

Cox, JL 1989, 'Can postnatal depression be prevented?', *Midwife Health Visitor and Community Nurse*, vol.25, pp.326–329.

Cox, J 1994, *Perinatal psychiatry: use and misuse of the EPDS*, London: Gaskell.

- Cross, R 2005, 'Accident and emergency nurses' attitudes towards health promotion', *Journal of Advanced Nursing*, vol.51, pp.474–483.
- Cuerto, M 2004, 'The origins of Primary Health Care and Selective Primary Health Care', *American Journal of Public Health*, November, vol. 94, no. 11, pp.1864-1874.
- Cutrona C & Troutman B, 1990, 'Nonpsychotic postpartum depression among adolescent mothers', *Journal of Abnormal Psychology*, vol.99, p.69.
- Cypres, A, Landsberg, G, Spellmann, M 1997, 'The impact of managed care on community mental health outpatient services in New York State, *Administration and Policy in Mental Health*, vol.24, no.6, pp.509–521.
- Darbyshire, P 2004, 'Rage against the machine?': nurses' and midwives' experiences of using Computerized Patient Information Systems for clinical information', *Journal of Clinical Nursing*, vol.13, pp.17–25.
- Davies, JK 2013, 'Health promotion: A unique discipline?', *Health Promotion Forum of New Zealand*, Auckland.
- Davis, B & Allen, D 2007, 'Integrating 'mental illness' and 'motherhood': The positive use of surveillance by health professionals, A qualitative study', *International Journal of Nursing Studies*, vol.44, no.3, pp.365–376.
- Davis, H, Day, C & Bidmead, C 2002, *Working in Partnership with Parents: the Parent Adviser Model*, London, Harcourt Assessment.
- Dean, K 1996, 'Using theory to guide policy relevant health promotion research', *Health Promotion International*, vol.11, pp.19-26.
- DeFrain, JD & Assay, SM 2007, *Strong families around the world: Strengths-based research and perspectives*, Harworth Press/Taylor and Francis.
- DeFrain, JD & Stinnett, N 2002, Family strengths, In JJ Ponzetti, Jr. (Ed.), *International encyclopedia of marriage and family* (2nd ed., pp.637-642), New York, Macmillan Reference Group.

de la Cuesta, C 1994, 'Relationships on health visiting: Enabling and mediating', *International Journal of Nursing Studies*, vol.31, no.5, pp. 451–459.

De Laine, M 1997, *Ethnography: theory and applications in health research*, Sydney: MacLennan & Petty.

de Montigny, F & Lacharite, C 2008, 'Modeling parents' and nurses' relationships', *Western Journal of Nursing Research*, vol.30, no.6, pp.734-58.

Dennis, CL & Creedy, D 2004, 'Psychosocial and psychological interventions for preventing postpartum depression', *Cochrane Database Syst Rev*, Oct, vol.8, no.4, CD001134.

Denzin, N & Lincoln, L (Eds.) *Handbook of qualitative research*, Thousand Oaks, CA: Sage.

Department of Health and Human Services (DHHS) 2009, *Child Health and Parenting: Strategic Health Plan 2009-2014*.

Department of Health and Human Services (DHHS) 2009, *Building the foundations for mental health and wellbeing: A Strategic Framework and Action Plan for Implementing Promotion, Prevention and Early Intervention (PPEI) Approaches in Tasmania*, A Summary and Government Response.

Department of Health and Human Services (DHHS) 2009, 'cu@home: A Nurse Home Visiting Program for Young Parents', Service Delivery Model.

de Saint-Exupery 1943, *The Little Prince*, Piccolo Books.

Dingwall, R & Robinson, K 1993, 'Policing the family? Health visiting and the public surveillance of private behaviour, In A Beattie, M Gott, L Jones & M Sidell (Eds.), *Health and wellbeing: A reader* (pp. 165–173). London: Open University and MacMillan.

Doherty, ME 2009, 'Therapeutic alliance: A concept for the childbearing season', *The Journal of Perinatal Education*, vol.18, no.3, pp.39–47.

Doherty, ME 2012, 'Midwifery Care: Reflections of Midwifery Clients', *The Journal of Perinatal Education*, vol.19, no.4, pp.41–51.

Donovan, RJ, Henley, N, Jallah, G, Silburn, SR, Zubrick, SR & Williams, A 2007, 'People's Beliefs about Factors Contributing to Mental Health: Implications for Mental Health Promotion', *Health Promotion Journal of Australia* vol.18, pp.50-56.

Duncan, GJ, Dowsett, CJ, Claessens, A, Magnuson, K, Huston, AC et al. 2007, 'School readiness and later achievement', *Dev Psychol*, vol.43, no.6, pp.1428-46.

Dusing, SCM & Brown, SE 2004, 'Instituting parent education practices in the neonatal intensive care unit: An administrative case report of practice evaluation and statewide action', *Physical Therapy*, vol.92, no.7, pp.967–75.

Ely, M, Vinz, R, Downing, M & Anzul, M 1997, *On writing qualitative research: Living by words*, London, Routledge/Falmer.

Enkin, M 1990, 'Commentary: are the correct outcomes of prenatal education being measured?', *Birth*, vol.17, no.2, p.73-74.

Eriksson, M & Lindstrom, B 2008, 'A salutogenic interpretation of the Ottawa Charter', *Health Promotion International*, vol.23, no.2, pp.190-199.

Fägerskiöld, AM & Wahlberg, V & AC 2000, 'What child health nurses believe mothers with infants expect of them', *Nursing and Health Sciences*, vol.2, pp.83–91.

Fahy, K 2007, 'An Australian history of the subordination of midwifery', *Women and Birth*, vol. 20, no. 1, pp. 25-29.

Falk-Rafael, AR 2001, 'Empowerment as a process of evolving consciousness: a model for empowered caring', *Advances in Nursing Science*, vol.21, no.1.

Fine, M 1994, Dis-tance and other stances: Negotiations of power inside feminist research. In Gitlin, A (Ed.), *Power and methods* (pp.13-55). New York: Routledge.

Fine, M 2002, *Disruptive Voices: The Possibilities for Feminist Research*, Ann Arbor: University.

Foley, DE 2002, 'Critical ethnography: The reflexive turn', *International Journal of Qualitative Studies in Education*, vol.15, no.4, pp.469-490.

Fontaine, KR & Jones, LC 1997, 'Self-esteem, optimism and postpartum depression', *Journal of Clinical Psychology*, vol.53, pp.59–63.

Fontana, A & Frey, JH 2008, 'The Interview: From Neutral Stance to Political Involvement', in NK Denzin & YS Lincoln (eds), (2008) *Collecting and Interpreting Qualitative Materials* (Third edition) London, Thousand Oaks, New Delhi: Sage Publications.

Forbes, A, While, A, Ullman, R & Murgatroyd, B 2007, 'The contribution of nurses to child health and child health services: findings of a scoping exercise', *Journal of Child Health Care*, vol.11, no.3, pp.231–247.

Forest, D 1989, 'The experience of caring', *Journal of Advanced Nursing*, vol.14, pp.815-823.

Forster, D, McLachlan, H, Yelland, J, Rayner, J, Lumley, J 2005, *PinC, a Review of In-Hospital Postnatal Care in Victoria, Final Report*, LaTrobe University, Melbourne.

Forster, DA, McLachlan, HL, Yelland, JS, Rayner, J, Lumley, J & Davey, MA 2006, 'Staffing in postnatal units: is it adequate for the provision of quality care? Staff perspectives from a state-wide review of postnatal care in Victoria, Australia', *BMC Health Services Research*, vol.6, p.83.

Foucault, M 1980, *Power/Knowledge: Selected Interviews and Other Writings 1972–1977*, Brighton, Sussex, Harvester Press.

Foucault, M 1991, *Discipline and punish: the birth of the prison* (A Sheridan, trans.), London, Penguin.

Foucault, M 1993, 'About the Beginning of the Hermeneutics of the Self' (Transcription of two lectures in Dartmouth on Nov. 17 and 24, 1980), ed. by Mark Blasius, in: *Political Theory*, vol. 21, no. 2, May, pp. 198-227.

- Fowler, C 2005, *Child and family health nursing practice learning package*, Tresillian Family Care Services, Sydney.
- Freund, A 2008, Expectations and experiences of first-time mothers, Master's thesis, Indiana University.
- Friedli, L, Parsonage, M 2007, *Mental Health Promotion: Building an Economic Case*, Northern Ireland Association for Mental Health, Belfast.
- Friedson, E 1970, *Professional dominance: the social structure of medical care*, New York, Atherton Press.
- Funnell MM, Anderson RM, Arnold MS et al. 1991, 'Empowerment: an idea whose time has come in diabetes education', *The Diabetes Educator*, vol.17, no.1, pp.37–41.
- Gagnon, AJ & Sandall, J 2009, 'Individual or group antenatal education for childbirth or parenthood, or both', *Cochrane Database of Systematic Reviews*, no.4, GD002869.
- Gallie, WB 1956, 'Essentially contested concepts', *Proceedings of the Aristotelian Society*, vol.56, pp.167–198.
- Gamble, J, Creedy, D, Moyle, W, Webster, J, McAllister, M & Dickson, P 2005, 'Effectiveness of a counselling intervention following a traumatic childbirth: A randomized controlled trial', *Birth*, vo.32, no.1, pp.11-19.
- Geanellos, R 2002, 'Transformative change of self: the unique focus of (adolescent) mental health nursing?', *International Journal of Mental Health Nursing*, vol.11, pp.174-85.
- Germov, J 2002, 'Challenges to medical dominance', in J Germov, *Second Opinion*, (2nd ed), pp.283-308, Melbourne, Oxford University Press.
- Gilkison, A 1991, 'Antenatal education – whose purposes does it serve?' *New Zealand College of Midwives Journal*, vol.1, pp.13-15.

Giroux, H 1983, *Theory and resistance in education: a pedagogy for the opposition*, Massachusetts: Bergin & Garvey Publishers.

Giroux, H & McLaren, P 1996, *Between borders: pedagogy and the politics of cultural studies*, New York: Routledge.

Goetz, JP & LeCompte, MD 1984, *Ethnography and qualitative design in educational research*, New York: Academic Press.

Goffman, E 1963 (ed.), 'Stigma: notes on the management of spoiled identity', Englewood Cliffs: Prentice Hall.

Goffman, E 1968, 'The moral career of the mental patient. In: Spitzer SP, Denzin NK, editors, *The mental patient*, New York: McGraw-Hill, pp. 226–234.

Gonser, P & McGuiness, T 2001, 'Theoretical underpinnings of health promotion in acute care', *Nurse Practitioner Forum*, vol.12, pp.147–150.

Government of South Australia *Children Youth and Women's Health Service 2005*, Family home visiting service outline.

Grbich, C 1999, *Qualitative research in health: an introduction*, NSW: Allen and Unwin.

Guba, E & Lincoln, Y 2005, Paradigmatic controversies, contradictions, and emerging confluences. In N Denzin & Y Lincoln (Eds.), *The Sage handbook of qualitative research* (pp. 191-215). Thousand Oaks: Sage.

Guest, EM & Keatinge, DR 2009, 'The Value of New Parent Groups in Child and Family Health Nursing', *The Journal of Perinatal Education*, vol.18, no.3, pp.12–22.

Gunn J, Hegarty K, Nagle C, Forster D, Brown S, Lumley J 2006, 'Putting woman centered care into practice: a new (ANew) approach to psychosocial risk assessment during pregnancy', *Birth*, vol.33, no.1, pp.46–55.

Hagan JF, Shaw JS, Duncan P (eds) 2008, *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*, Third Edition, Pocket Guide, Elk Grove Village, IL, American Academy of Pediatrics.

Halbreich, U & Kardun, S 2005, 'Cross-cultural and social diversity of prevalence of postpartum depression and depressive symptoms', *Journal of Affective Disorders*, 91(2006), 97-111.

Hall, D 1996, '*Health for All Children*', (3rd ed), Oxford University Press, Oxford.

Hancock, A 1994, 'How effective is antenatal education?' *Modern Midwife*, May, 4(5), 13-15.

Hanson, L, VandeVusse, L, Roberts, J & Forristal, A 2009, 'Critical Appraisal of Guidelines for Antenatal Care: Components of Care and Priorities in Prenatal Education', *Journal of Midwifery and Women's Health*, vol.54, no.6, November/December, pp.458-468.

Harrison, S & Armad, WIU 2000, 'Medical Autonomy and the UK State 1975 to 2025', *Sociology*, vol.34, pp.129-146.

Hart, A & Lockey, R 2002, 'Inequalities in health care provision: the relationship between contemporary policy and contemporary practice in maternity services in England'. *Journal of Advanced Nursing*, vol.37, no.5, pp.485-493.

Henderson, J 2007, 'The National Mental Health Strategy: Redefining Promotion and Prevention in Mental Health?', *Australian Journal of Primary Health*, vol. 13, no. 3, December, pp. 77-84.

Hermann, H 2001, 'The need for mental health promotion', *Australian and New Zealand Journal of Psychiatry*, vol.35, pp.709-715.

Herrman, H & Jane-Llopis E 2005, Mental health promotion in public health, *Promotion and Education*, Supplement 2, pp.42-46.

Herrman, H, Saxena, S, Moodie, R, & Walker, L 2005, Introduction: Promoting Mental Health as a Public Health Priority, In H Herrman, S Saxena, & R Moodie (Eds.), *Promoting Mental Health: Concepts, Emerging Evidence, Practice* (pp. 2-15), Geneva, World Health Organization.

Herrman, H, Saxena, S & Moodie, R (eds) 2005, *Promoting Mental Health: Concepts, Emerging Evidence, Practice*, A Report of the World Health Organization, Department of Mental Health and Substance Abuse in Collaboration with the Victorian Health Promotion Foundation and University of Melbourne, WHO, Geneva.

Herzlinger, RE 2004, *Consumer-Driven Health Care*, San Francisco, Calif: Jossey-Bass.

Hetherington, SE 1990, 'A controlled study of the effects of prepared childbirth classes on obstetric outcomes', *Birth*, vol.17, no.2, pp.86–91.

H Goddard, M, Hauck, K, Precker, A & Smith, CP 2006, 'Priority setting in health – a political economy perspective', *Health Economics, Policy and Law*, vol.1, pp.79-90.

Hipwell, A, Goossens, F, Melhuish, E & Kumar, R 1999, 'Severe maternal psychopathology and infant-mother attachment', *Developmental and Psychopathology*.

Henderson, S 2009–10, 'Community Child Health (CCH) nurses' experience of home visits for new mothers: A quality improvement project', *Contemporary Nurse*, vol.34, no.1, pp.66–76.

Holden, J 1996, 'The role of health visitors in postnatal depression', *International Review Of Psychiatry*, vol.8, pp.79–86.

Holstein, J & Gubrium, J 2003, Inside interviewing: New lenses, new concerns, In J Holstein & J Gubrium (Eds.), *Inside interviewing: New lenses, new concerns* (pp. 3-30), Thousand Oaks: Sage.

Holloway, I & Todres, L 2003, 'The status of method: flexibility, consistency and coherence', *Qualitative Research*, vol.3, no.3, pp.345-357.

Homer, C & Caplice, S 2007, *Evaluation of the publicly-funded homebirth program in South East Sydney Illawarra Area*, St George Homebirth Program.

- Homer, C, Passant L, Brodie, P, Kildea, S, Leap, S, Pincombe J, et al. 2009, 'The role of the midwife in Australia: views of women and midwife', *Midwifery*, vol.25, no.6, pp.673–81.
- Hyde, A, Treacy, MM, Scott, AP, Butler, M, Drennan, J, Irving, K et al. 2005, Modes of rationality in nursing documentation: biology, biography and the voice of nursing. *Nursing Inquiry*, vol.12, pp.66–77.
- Irvine, F 2007, 'Examining the correspondence of theoretical and real interpretations of health promotion', *Journal of Clinical Nursing*, vol.16, pp.593–602.
- Jack, SM, DiCenso, A & Lohfeld, L 2005, 'A theory of maternal engagement with public health nurses and family visitors', *Journal of Advanced Nursing*, vol.49, no.2, pp.182–190.
- Jaddoe, VW 2009, Antenatal education programmes: Do they work? *Lancet*, vol.374, no.9693, pp.863-864.
- Jahoda, M 1958, *Current Concepts of Positive Mental Health*, Basic Books, New York.
- Jané-Llopis, E 2005, 'From evidence to practice: mental health promotion effectiveness', *Promotion and Education*, Supplement 1, pp. 21-27.
- Jane-Llopis, 2007, 'Mental health promotion: concepts and strategies for reaching the population', *Health Promotion Journal of Australia*, vol.18, pp.191-7.
- Jane-Lopis, E, Barry, MM, Hosman, C & Patel, V 2005, 'Mental health promotion works: a review', *Promotion and Education*, vol.61, no.67 (Suppl. 2), pp.9–25.
- Jane-Llopis, E 2006, 'From evidence to practice: mental health promotion effectiveness', *Australian e-Journal for the Advancement of Mental Health* (AeJAMH), vol.5, no.1.
- Jane-Llopis, E, Katschnig, H, McDaid, D & Wahlbeck, K 2011, 'Strengthening evidence for mental health promotion', *Health Promotion International*, vol.26, pp.140–i146.

- Jeffs, D & Harris, M 1993, 'The personal health record: Making it work better for general practitioners', *Aust Fam Physician*, vol.22, no.8, pp.1417-1421.
- Jones CJ, Creedy DK, Gamble JA 2012, 'Australian midwives' attitudes towards care for women with emotional distress', *Midwifery*, vol. 28, no.2, pp.216–21.
- Jones CJ, Creedy DK, Gamble JA 2011, 'Australian midwives' knowledge of antenatal and postpartum depression: a national survey', *Journal of Midwifery and Women's Health*, vol. 56, no.4, pp.353–61.
- Jorm, AF 2012, 'Mental Health Literacy: Empowering the Community to Take Action for Better Mental Health', *American Psychologist*, vol. 67, no. 3, pp.231–243.
- Kalekin-Fishman, D 2002, 'Looking at Interviewing: From "Just Talk" to Meticulous Method', Forum: *Qualitative Social Research*, vol.3, no. 4, art. 38.
- Kantorowski, L 1992, Issues of early professionals in counseling psychology: community mental health centers, *Counseling Psychologist*, vol.20, no.1, pp.61–66.
- Keleher, H 2001, 'Why Primary Health Care Offers a more Comprehensive Approach to Tackling Health Inequalities than Primary Care', *Australian Journal of Primary Health*, vol.7, no.2, pp.57-61.
- Keyes, CLM 2007, Towards a mentally flourishing society: mental health promotion, not cure, *Journal of Public Mental Health*, Jun vol.6, no.2, pp.4-6.
- Keyes, CLM 2005, Subjective wellbeing in mental health and human development research world wide: an introduction, *Social Indicators Research*, vol.77, pp.1–10.
- Kickbush, I 1996, 'Tribute to Aaron Antonovsky', *Health Promotion International*, vol. 11, no. 1, pp.5-6.
- Kincheloe, JL, McLaren, P & Steinberg, SR 2011, 'Critical pedagogy, and qualitative research: Moving to the bricolage', in NK Denzin & YS Lincoln (Eds.), *The Sage handbook of qualitative research* (4th ed., pp. 163-178). Los Angeles: Sage.

- Kim, J, Hongju, J & Bates, D 2011, 'History and Trends of "Personal Health Record"', *Healthc Inform Res*, vol.17, no.1, pp.3-17.
- Kingwell, M 2001, 'What Does It All Mean?', *The Wilson Quarterly* (1976-), vol. 25, no. 2 (Spring), pp.35-43.
- Kirk, S & Glendinning, C 2002, Supporting 'expert' parents: professional support and families caring a child with complex health care needs in the community, *International Journal of Nursing Studies*, vol.39, pp.625-635.
- Kirkham, 1999, 'The culture of midwifery in the National Health Service in England', *Journal of Advanced Nursing*, vol.30, no.3, pp.732-739.
- Kitzinger, S 1992, *Ourselves as mothers: The universal experience of motherhood*, New York, Addison-Wesley.
- Knapman, C 1993, 'Reconstructing Mothering: Feminism and the Early Childhood Centre' *Australian Feminist Studies*, vol. 18, Summer.
- Knapp, L 1996, 'Childbirth satisfaction: The effects of internality and perceived control', *The Journal of Perinatal Education*, vol.5, no.14, pp.7-16.
- Kruske, S, Barclay, L & Schmied, V 2006, 'Primary health care, partnership and polemic: child and family health nursing support in early parenting', *Australian Journal of Primary Health*, vol.12, no.2, pp.57-65.
- Kvale, S 1996, *Interviews*, London: Sage.
- Labonte, R 1990, 'Health Promotion and Empowerment: Practice frameworks', *Issues in Health Promotion Series HP10-0102*, Centre for Health Promotion, University of Toronto.
- Lagerberg, D, Magnusson, M & Sundelin, C 2008, *Child Health in transition, results of an intervention trial*, Stockholm, Gothia Förlag.

Lahtinen, E, Joubert, N, Raeburn, J & Jenkins, R 2005, 'Strategies for Promoting the Mental Health of Populations', In H Herrman, S Saxena, & R Moodie (Eds.), *Promoting Mental Health: Concepts, Emerging Evidence, Practice* (pp. 226-242), Geneva, World Health Organization.

Lally, S 1989, 'Does being in here mean there is something wrong with me?', *Schizophrenia Bulletin*, vol.15, no.2, pp.235-65.

Langford, CPH, Bowsher, J, Maloney, JP & Lillis, PP 1997, 'Social support: A conceptual analysis', *Journal of Advanced Nursing*, vol.25, no.1, pp.95–100.

Lavikainen, J, Lahtinen, J & Lehtinen, V 2000, '*Public Health Approach on Mental Health in Europe*', National Research and Development Centre for Welfare and Health, STAKES Ministry of Social Affairs and Health.

Lederman, RP 1996, '*Psychosocial adaptation in pregnancy: Assessments of seven dimensions of maternal development*, (2nd ed.), New York, Springer.

Lees, D, Procter, N & Fassett, D 2014, 'Therapeutic engagement between consumers in suicidal crisis and mental health nurses', *International Journal of Mental Health Nursing*, vol. 23, pp.306–315.

Lewis, J 2006, 'Being around and knowing the players: networks of influence in health policy', *Social Science & Medicine*, vol.62, no.9, pp.2125-36.

Li, J, McMurray, A & Stanley, F 2008, 'Modernity's paradox and the structural determinants of child health and wellbeing', *Health Sociology Review*, vol.17, no.1, pp.64-77.

Li, Z, Zeki R, Hilder, L & Sullivan, EA 2013, *Australia's mothers and babies 2011, Perinatal statistics series no. 28*. Cat. no. PER 59. Canberra: AIHW National Perinatal Epidemiology and Statistics Unit.

Liaschenko, J 1994, 'Making a bridge: the moral work with patients we do not like', *Journal of Palliative Care*, vol.10, pp.83–89.

Lin, V & Fawkes, S 2007, 'Health promotion in Australia: twenty years on from the Ottawa Charter', *Promotion & Education*, vol.14, pp.203.

Lincoln, YS 1991, 'Self, subject, audience, text: living at the edge, writing in the margins', in WG Tierney & YS Lincoln (eds), *Representation and the text: Reframing the narrative voice*, State University of New York Press.

Locke, A & Horton-Salway, M 2010, 'Golden Age' versus 'Bad Old Days' : A Discursive Examination of Advice Giving in Antenatal Classes', *Journal of Health Psychology*, vol.15, no.8, pp.1214–1224.

Long, D, Forsyth, R, Iedema, R & Carroll, K 2006, 'The impossibilities of clinical democracy', *Health Sociology review*, vol.15, no.5, pp.506-519.

Lothian, JA 2008, 'The journey of becoming a mother', *Journal of Perinatal Education*, vol.17, no.4.

Lumley, J, Austin, MP & Creina, M 2004, 'Intervening to reduce depression after birth: A systematic review of the randomized trials', *International Journal of Technology Assessment in Health Care*, vol.20, pp.128-144.

Lumley, J & Brown, S 1993, 'Attenders and nonattenders at childbirth education classes in Australia: how do they and their births differ?', *Birth*, 20, 123–130.

Lupton, D 2000, 'A love/hate relationship': the ideals and experiences of first-time Mothers', *Journal of Sociology*, vol.36, no.1.

Lyons-Ruth, K, Zoll, D, Connell, D & Grunebaum, HU 1986, 'The depressed mother and her one-year-old infant: Environment, interaction, attachment and infant development, In EZ Tronick & T Field (Eds.), *Maternal depression and infant disturbance* (p. 34), San Francisco, Jossey-Bass.

Maas, A, Vreeswijk, C, de Cock, E, Rijk, C & van Bakel, H 2012, "Expectant parents": Study protocol of a longitudinal study concerning prenatal (risk) factors and postnatal infant development, parenting, and parent-infant relationships', *BMC Pregnancy & Childbirth*, vol.12, no.1, pp.46–53.

- Macdonald, G & Bunton, R 2002, 'What is health promotion?' In Bunton, R & Macdonald, G (eds), *Health promotion: disciplines, diversity and developments*, (2nd ed), London, Routledge.
- MacLennan, AH, Wilson, DH, & Taylor, AW 1996, 'Prevalence and cost of alternative medicine in Australia', *Lancet*, Mar vol. 347, no.9001, pp.569-73.
- Maggs, CA 1996, 'History of nursing: a history of caring', *Journal of Advanced Nursing*, vol.23, p.639.
- Malinowski, B 1967, *A diary in the strict sense of the term*, (N Guterman, trans), London: Routledge and Kegan Paul.
- Manderscheid, RW, Ryff, CD, Freeman, EJ, McKnight-Eily, LR, Dhingra S & Strine TW 2010, 'Evolving definitions of mental illness and wellness', *Prev Chronic Dis*, vol.7, no.1, pp.1-6.
- Manias, E & Street, A 2001, 'Rethinking ethnography: reconstructing nursing relationships', *Journal of Advanced Nursing*, vol. 33, no.2, pp.234-242.
- Mann, K 1936, '*Mephisto*', Penguin Classics.
- Marcellus, L 2005, 'The ethics of relation: public health nurses and child protection clients', *Journal of Advanced Nursing*, vol.51, no.4, pp.414-420.
- Margolies, L 1989, *Postpartum and recurring depression on mothers and its effects on their children: a longitudinal study*, Unpublished dissertation, Long Island University.
- Marmot, M 1999, 'The Solid Facts: The Social Determinants of Health', *Health Promotion Journal of Australia*, vol.9, no.2, pp.133-139.
- Maslow, AH 1950, 'Self-actualizing people: a study of psychological health. Personality', *Symposium*, vol 1, p.11-34.
- Mason, J 2002, *Qualitative researching* (2nd ed), Thousand Oaks, CA, Sage Publications.

Matthey, S, Kavanagh, D, Howie, P, Barnett, B & Charles, M 2004, 'Prevention of postnatal distress or depression: An evaluation of an intervention at preparation for parenthood classes', *Journal of Affective Disorders*, 79, 113-126.

McCain, M, Mustard, F 2011, *Early Years Study 3*, Toronto: Margaret & Wallace McCain Family Foundation.

McDaid, D 2008, 'The social and economic impact of mental health: meeting the challenge', In Kaye, C & Howlett, M, (eds.), *Mental Health Services Today and Tomorrow - Part 2*. Radcliffe Medical Press, Oxford, UK, 19-34.

McDaid, D & Park, A 2011, 'Investing in mental health and wellbeing: findings from the DataPREV project', *Health Promotion International*, vol.26, pp.108–i139.

McKay, S & Yager-Smith, S 1993, 'What are they talking about? Is something wrong? Information sharing during the second stage of labour', *Birth*, 20(3), 42-47.

McKellar, LV, Pincombe, JI & Henderson, AM 2006, 'Insights from Australian parents into educational experiences in the early postnatal period', *Midwifery*, vol. 22, pp. 356–364.

McLachlan, H, Forster, D, Yelland, J, Rayner, J & Lumley, J 2008, 'Is the organisation and structure of hospital postnatal care a barrier to quality care? Findings from a state wide review in Victoria, Australia', *Midwifery*, vol.24, pp. 358–370.

McLachlan, HL, Forster, DA, Collins, R, Gunn, J & Hegarty, K 2011, 'Identifying and supporting women with psychosocial issues during the postnatal period: Evaluating an educational intervention for midwives using a before-and-after survey', *Midwifery*, vol. 27, pp.723–730.

McLaren, P 1988, 'Language, social structure and the production of subjectivity', *Critical Pedagogy Networker*, May/June, vol.2, no.3, pp.1-10.

McLellan, AT, Kleber, HD, Carise, D 2003, 'The national addiction treatment infrastructure: Can it support the Public's demand for quality care', *Journal of Substance Abuse Treatment* vol.25, pp.117–121.

- McMurray, A 1993, *Community Health Nursing: Primary Health Care in practice*, Melbourne, Churchill Livingstone.
- McMurray, A 2007, 'Leadership in primary health care: An international perspective', *Contemporary Nurse*, vol. 26, pp.30–36.
- McMurray, A 2011, 'The enabling community for child and family health', *Contemporary Nurse*, vol. 40, no.1, pp. 2–4.
- McMurray, A & Clendon, J 2011, *Community health and wellness: Primary Health Care in practice* (4th ed.), Sydney, Elsevier.
- McNeill, J, Doran, J, Lynn, F, Anderson, G & Alderdice, F 2012, *BMC Pregnancy and Childbirth*, no.12, p.142.
- McPherson, L, Mann J, Williamson, A & Finn, M 1980, 'An evaluation of the aims, tasks and priorities of the Infant Welfare Service in Victoria', *The Australian Nurses' Journal*, vol.10, no.4, pp.32-33.
- McVicar, A 2003, 'Workplace stress in nursing: a literature review', *J Adv Nurs*, vol.44, pp. 633–642.
- Mein Smith, P 1997, *Mothers and king baby: infant survival and welfare in an imperial world, Australia 1880-1950*, Macmillan Press, London.
- Mercer, J 2006, *Understanding Attachment: Parenting, Child Care, and Emotional Development*, Westport, CT: Praeger.
- Merchant, DC, Affonso, DD & Mayberry, LJ 1995, 'Influence of marital relationship and child-care stress on maternal depression symptoms in the postpartum', *Journal of Psychosomatic Obstetrics and Gynaecology* supplementary, vol.16, pp.193–200.
- Merton, RK 1973, 'The Normative Structure of Science', in RK Merton, *The Sociology of Science*, Chicago: University of Chicago Press: 267-78.
- Michaels, P, Lopez, M, Rusch, N & Corrigan, P 2012, 'Constructs and concepts comprising the stigma of mental illness', *Psychology, Society, & Education*, vol. 4, no 2, pp.183-194.

Milgrom, J, Ericksen, J, Negri, L & Gemmill, AW 2005, 'Screening for postnatal depression in routine primary care: properties of the Edinburgh Postnatal Depression Scale in an Australian sample', *Aust N Z J Psychiatry*, vol.39, no.9, pp.833-9.

Mills, CW 1959, *The sociological imagination*, New York: Oxford University Press.

Mischler, E 1986, *Research interviewing: Context and narrative*. Cambridge, Massachusetts: Harvard University Press.

Mishler, EG 1989, Critical perspectives on the biomedical model, In P Brown, (ed), *Perspectives in medical sociology*, Belmont, California, Wadsworth.

Mitcheson, J & Cowley, S 2003, 'Empowerment or control? An analysis of the extent to which client participation is enabled during health visitor/ client interactions using a structured health needs assessment tool', *International Journal of Nursing Studies*, vol.40, no.4, pp.413–426.

Mittelmark, M 2005, 'Why mental health promotion?' *Promotion and Education*, Suppl 2, p.55.

Moodie 1999, 'Mental Health: A Contested Standard', *Health Promotion Journal of Australia*, vol.9, no.2, pp.79-80.

Moodie, R & Jenkins, R 2005, 'I'm from the government and you want me to invest in mental health promotion. Well why should I?' *Promotion and Education*, Supplement 2, The evidence of mental health promotion effectiveness: strategies for action, pp.37-41.

Moore, KA, Whitney, C & Kinukawa, A 2009, '*Exploring the links between family strengths and adolescent outcomes*', Child Research Brief, April, Washington.

Monk, AR, Tracy, SK, Foureur, M, & Tracy, M 2013, 'Evaluating midwifery units (EMU): Lessons from the pilot study', *Midwifery*, vol.29, pp.845–851.

Morrow, J, Forster, D, McLachlan, H, et al. 2011, 'Enhancing postnatal care: exploring women's views and experiences of 'new look' postnatal care'. *Journal of Paediatrics and Child Health*, vol.47 (Suppl.s1), p.29.

Mrazek, PJ & Haggerty, RJ editors 1994, *Reducing the risks for mental disorders: Frontiers for preventive research*, Washington DC, National Academy Press, 19-30.

Murray, L, Fiori-Cowley, A, Hooper, R, Cooper, P 1996, 'The impact of postnatal depression and associated adversity on early mother-infant interactions and later infant outcome' *Child Dev*, vol. 67, no.25, pp.12-26.

Mustard, F 2008, *Investing in the Early Years: Closing the Gap Between What We Know and What We Do*, South Australia:Government of South Australia.

Murray, L 1992, 'The impact of postnatal depression on infant development', *Journal of Child Psychology and Psychiatry*, vol.33, pp.543–561.

Murray L, Sinclair D, Cooper P, Ducournau P, Turner P, Stein, A 1999, 'The socioemotional development of 5-year-old children of postnatally depressed mothers', *J Child Psychol Psychiatry*, vol.40, no.12, pp.59-71.

National Health and Medical Research Council 2008, *An Information Paper. Postnatal depression: A systematic review of published scientific literature to 1999*, revised 2008, Commonwealth of Australia.

National Institute for health and clinical excellence (NICE) 2006, '*Routine postnatal care of women and their babies: Clinical management and service guidance*', NICE clinical guideline 37.

National Institute for health and clinical excellence (NICE) 2007, '*Antenatal and postnatal mental health: Clinical management and service guidance*', NICE clinical guideline 45.

National Institute for health and clinical excellence (NICE) 2008, '*Antenatal care: Routine care for healthy pregnant woman*', National Collaborating Centre for Women's and Children's Health.

National Institute for health and clinical excellence (NICE) 2010, '*Antenatal care: Clinical management and service guidance*', NICE clinical guideline 62.

New South Wales (NSW) Department of Health, 2009, *NSW Health/Families NSW Supporting Families Early Package – SAFE START Guidelines: Improving mental health outcomes for parents and infants*, NSW Department of Health.

New South Wales (NSW) Health 2005, *Child and Family Health Nursing*. Retrieved 2nd November 2010, from <http://www.health.nsw.gov.au/>

New South Wales (NSW) Ministry of Health 2012, *Midwifery Continuity of Carer Model Tool-kit*, The Nursing & Midwifery Office, Sydney, NSW.

New South Wales (NSW) Standing Committee on Social Issues 1998, '*Working for children: communities supporting families*', *Inquiry into parent education and support programs*, Sydney, Australia: New South Wales Government.

Nichols, MR 1995, 'Adjustment to new parenthood: attenders verses nonattenders at prenatal education classes', *Birth*, 22, 21-26.

Nightingale, D & Cromby, J (Eds) 1999, *Social constructionist psychology*, Buckingham, Open University Press.

Noblit, GW, Flores, SY & Murillo, EG (Eds) 2004, *Postcritical ethnography: An introduction*, Cresskill NJ: Hampton.

Nolan, ML 1997, 'Antenatal education: where next?', *Journal of Advance Nursing*, 25, 1198–1204.

Nolan, M 2005, 'Childbirth and parenting education: What the research says and why we may ignore it', In M Nolan & J Foster (Eds.), *Birth and parenting skills: New directions in antenatal education* (pp. 1–16), Edinburgh, Scotland, Churchill Livingstone.

Norton, L 1998, 'Health promotion and health education: what role should the nurse adopt in practice?', *Journal of Advanced Nursing*, vol.28, pp.1269–1275.

Nutbeam, D 1998, 'Health promotion glossary', *Health Promotion International*, vol.13, no.4, pp.349-364.

- Nyatanga, L & Dann, KL 2002, 'Empowerment in nursing: the role of philosophical and psychological factors', *Nursing Philosophy*, vol.3, pp. 234–239.
- Oakley, A, Rajan, L & Grant, A 1990, 'Social support and pregnancy outcome', *British Journal of Obstetrics and Gynaecology*, vol.97, pp.155–162.
- Oberle, K & Tenove, S 2000, 'Ethical issues in public health nursing', *Nursing Ethics*, vol.7, pp.426–438.
- O'Brien, L 2000, 'Nurse-client relationships: the experience of community psychiatric nurses', *Australia and New Zealand Journal of Mental Health Nursing*, vol.9, pp.184–194.
- O'Flaherty, S, Jandera, E, Llewellyn, J & Wall, M 1987, 'Personal health records: an evaluation', *Arch Dis Child*, vol.62, pp.1152–1155.
- O'Hara, MW & Swain, AM 1996, 'Rates and risk of postpartum depression – a meta-analysis', *International Review of Psychiatry*, 8, 37–54.
- Olson, DH & DeFrain, J 2000, *Marriage and the Family Diversity and Strengths* (3rd edn), Mayfield, MountainView, CA.
- Olson, DH, DeFrain, JD & Skogrand, L 2010, *Marriages and Families: Intimacy, Diversity, and Strengths*, Barnes & Noble.
- O'Meara, CM 1993a, 'An evaluation of consumer perspectives of childbirth and parenting education', *Midwifery*, vol.9, pp.210–219.
- O'Meara, CM 1993b, 'Childbirth and parenting education — the provider's viewpoint'. *Midwifery*, vol.9, pp.76–84.
- Osborne, JW 1998, 'Some similarities and differences among phenomenological and other methods of psychological qualitative research', *Canadian Psychology*, vol.35, no.2, pp.167–189.
- Paley, J, Cheyne, H, Dalglish, L, Duncan, EA & Niven, CA 2007, 'Nursing's ways of knowing and dual process theories of cognition', *J Adv Nurs*, vol.60, no.6, pp.692–701.

- Patton, M 1990, *Qualitative evaluation and research methods* (2nd Ed), Newbury Park, CA: Sage.
- Payton, AR 2009, 'Mental Health, Mental Illness, and Psychological Distress: Same Continuum or Distinct Phenomena?', *Journal of Health and Social Behavior*, Jun, vol.50, no.2, pp. 213-227.
- Peckover, S 2002, 'Supporting and policing mothers: an analysis of the disciplinary practices of health visitors', *Journal of Advanced Nursing*, vol.38, no.4, p.369–377.
- Petersson, K, Petersson, C, & Hakansson, A 2004, 'What is good parental education? Interviews with parents who have attended parental education sessions', *Scand J Caring Sci.*, 18, 82–89.
- Polanyi, M 1958, *Personal Knowledge, Towards a Post Critical Philosophy*, London, Routledge.
- Polkinghorne, D 1989, Phenomenological research methods, In RS Valle & S Hailing (Eds.), *Existential-phenomenological perspectives in psychology* (pp. 41-60). New York: Plenum Press.
- Pollett, H 2007, *Mental health promotion: A literature review*, Ottawa, ON, Mental Health Promotion Working Group of the Provincial Wellness Advisory Council, Canadian Mental Health Association.
- Porter-O'Grady, T & Malloch, K 2006, 'Partnership economics: creating value through evidence-based workload management', in K Malloch & T Porter-O'Grady, eds., *Introduction to Evidence-based Practice in Nursing and Health care*. Sudbury, Massachusetts: Jones and Bartlett Publishers, pp. 183-220.
- Post and Antenatal Depression Association (PANDA) 2012, *The cost of perinatal depression in Australia: Final Report*, Deloitte Access Economics.
- Powers, P 2002, 'A discourse analysis of nursing diagnosis', *Qualitative Health Research*, vol.12, pp.945–965.

Price, SK & Masho, SW 2013, 'What Does It Mean When We Screen? A Closer Examination of Perinatal Depression and Psychosocial Risk Screening Within One MCH Home Visiting Program', *Matern Child Health J*, online access.

Proctor, N, Hamer, HP, McGarry, D, Wilson, RL & Froggatt T 2014, *Mental Health: a person centred approach*, Cambridge University Press.

Pugh, J, Twigg, D, Martin, T & Tapan, R 2012, 'Western Australia facing critical losses in its midwifery workforce: A survey of midwives' Intentions', *Midwifery*, vol.29, no.5, pp. 497-505.

Redman, S, Oak, S, Booth, P, Jensen, J & Saxton, A 1991, 'Evaluation of an antenatal education programme: characteristics of attenders, changes in knowledge and satisfaction of participants', *Australian and New Zealand Journal of Obstetrics and Gynaecology*, vol.31, no.4, pp.310-316.

Reifels, L, Bassilios, B, King, E, Fletcher, JR, Blashki, G & Pirkis, JE 2012, 'Innovations in primary mental healthcare', *Australian Health Review*.

Reiger, K 1985, *The disenchantment of the home: Modernizing the Australian family 1880–1940*, Oxford University Press, Melbourne, 1985.

Reiger, K & Lane, K 2012, 'How can we go on caring when nobody here cares about us?' Australian public maternity units as contested care sites', *Women and Birth*, vol.26, no.2, pp.133–137.

Renkert S, & Nutbeam D 2001, 'Opportunities to improve maternal health literacy through antenatal education: An exploratory study', *Health Promot Int.*, 16, 381-8.

Rifkin, SB & Walt, G 1986, 'Why health improves: Defining the issues concerning 'Comprehensive Primary Health Care' and 'Selective Primary Health Care'', *Social Science and Medicine*, 23(6), 559-566.

Roberts, SJ 1983, 'Oppressed group behaviour: implications for nursing', *Advances in Nursing Science*, vol.5, no.4, pp.21-30.

Robertson, A 1997, *Birth International's Essential Educator Book*, ACE graphics and Associates in Childbirth Education.

Robertson, A 1998, 'Shifting discourses on health in Canada: from health promotion to population health', *Health Promotion International*, vol.13, no.2, pp.155-166.

Robinson, S & Hill, Y 1995, 'Miracles take a little longer: Project 2000 and the health-promoting nurse', *International Journal of Nursing Studies*, vol.32, pp.568-579.

Rodríguez, C & des Rivières-Pigeon, C 2007, 'A literature review on integrated perinatal care', *International Journal of Integrated Care*, vol.7, no.28.

Rolfe, G 2006, 'Validity, trustworthiness and rigour: quality and the idea of qualitative research', *Journal of Advanced Nursing*, vol.53, no.3, pp.304–310.

Ross-Davie, M, Elliott, S, Sarkar, A & Green, L 2006, 'A public health role in perinatal mental health: Are midwives ready?', *British Journal of Midwifery*, vol.14, no.6, pp.330-334.

Rowe, R & Calnan, M 2004, *Trust relations in health care—the new agenda*, London: The Nuffield Trust.

Rowling 2003, 'School Mental Health Promotion—Theoretical, Conceptual and Practical Issues', *Australian Journal of Guidance & Counselling*, Vol.13, no.1, pp. 11–21.

Royal college of Psychiatrists 1993, *Prevention in Psychiatry, Council Report CR21*, London, Royal College of Psychiatrists.

Ruddick, F 2008, 'Hope, optimism and expectation', *Mental Health Practice*, vol.12, no.1, pp.33-35.

Ruddick, F 2013, 'Promoting mental health and wellbeing', *Nursing Standard*, vol.27, no.24, pp.35-39.

- Rupert, P, & Baird, K 2004, 'Managed care and the independent practice of psychology'. *Professional Psychology: Research and Practice*, vol.35, no.2, pp.185-193.
- Rush, KL, Kee, CC & Rice, M 2005, 'Nurses as imperfect role models for health promotion'. *Western Journal of Nursing Research*, vol.27, pp.166–183.
- Rycroft-Malone, J, Seers, K, Titchen, A , Harvey, G, Kitson, A & McCormack, B 2004, 'What counts as evidence in evidence-based practice?', *Journal of Advanced Nursing*, vol.47, no.1, pp. 81–90.
- Saffin, K & Macfarlane, A 1991, 'How well are parent held records kept and completed?' *Br J Gen Pract*, vol.41, no.347, pp.249-51.
- Safran, DG, Taira, DA, Rogers, WH et al. 1998, 'Linking primary care performance to outcomes of care', *J Fam Pract*, vol.47, pp.213–20.
- Sandelowski, M 1986, 'The problem of rigor in qualitative research', *ANS Adv Nurs Sci*, Apr, vol.8, no.3, p.27-37.
- Sandelowski, M & Barroso, J 2002, 'Reading Qualitative Studies', *International Journal of Qualitative Methods*, vol.1, no.1, pp.74-108.
- Sanders 2006, 'Assessing and Managing Women With Depression: A Midwifery Perspective', *J Midwifery Womens Health*, vol.51, pp.185–192.
- Santrock, JW 2007, *Children*, New York, McGraw.
- Sartorius, N & Henderson, AS 1992, 'The neglect of prevention in psychiatry', *Australian and New Zealand Journal of Psychiatry*, vol. 26, pp.550–553.
- Sartorius, N 1990, Preface, in Goldberg D, Tantom D, eds, *The public health impact of mental disorders*, Toronto, Hogrefe and Huber.
- Schmied, V, Homer, C, Kemp, L, Thomas, C, Fowler C & Kruske, S 2008a, 'Literature Review: The role and nature of universal health services for pregnant women, children and families in Australia', Collaboration for Research into Universal Health Services for Mothers and Children.

Schmied, V, Cooke, M, Gutwein, R 2008b, 'Time to listen: strategies to improve hospital-based postnatal care', *Women and Birth*, vol.21, pp.99–105.

Schmied, V Cooke, M, Gutwein, R, Steinlein, E & Homer, C 2009, 'An evaluation of strategies to improve the quality and content of hospital based postnatal care in a metropolitan Australian hospital', *Journal of Clinical Nursing*, vol.18, pp.1850–1861.

Schmied, V, Dovovan, J, Kruske, S, Kemp, L, Homer, C & Fowler, C 2011, 'Commonalities and challenges: A review of Australian state and territory maternity and child health policies', *Contemporary Nurse*, vol.40, no.1, pp.106–117.

Schmeid, V, Johnson, M, Norell, N & Austin, M-P et al. 2013, 'Maternal mental health in Australia and New Zealand: A review of longitudinal studies', *Women and Birth*, vol.26, pp.167–178.

Schultz, A 1972, *The phenomenology of the social world*, London: Heinemann.

Soyini Madison, D 2012, *Critical ethnography: method, ethics, and performance*, Thousand Oaks, CA: Sage.

Secker, J 1998, 'Current conceptualizations of mental health and mental health promotion', *Health Educ Res*, vol.13, no.1, pp.57–66.

Shearer, EL 1996, 'Commentary: randomized trials needed to settle question of impact of childbirth classes', *Birth*, vol.23, pp.206–8.

Shepherd, ML 2011, 'Behind the scales: Child and family health nurses taking care of women's emotional wellbeing', *Contemporary Nurse*, vol.37, no.2, pp.137–148.

Siegel, DJ 1999, 'The attachment system' in *The developing mind: how relationships and the brain interact to shape who we are*, Guildford Press, New York, London.

Simpson & Creehan 2008, *Perinatal Nursing*, 3rd Edition, Lippincott.

Sittner, BJ, Hudson, DB & DeFrain, J 2007, 'Using the concept of family strengths to enhance nursing', *The American Journal of Maternal/Child Nursing*, vol.32, no.6, pp.353-357.

Smith, BJ, Tang, KC & Nutbeam, D 2007, 'WHO Health Promotion Glossary: new terms', *Health Promot Int.*, Dec, vol.21, no.4, pp.340-5.

Smith, L 2011, '*Spiritual wellbeing and its relationship to adolescent resilience: a case study of Australian youth attending one local church*', PhD Dissertation, Melbourne, Australian National University.

Smith, L & Ford, K 2013, Communication with children, young people and families – a family strengths-based approach, in M Barnes & J Rowe (eds), *Child, youth and family health: Strengthening communities*, (pp.91-110), Australian, Elsevier.

Spiby, H, Henderson, B, Slade, P, Escott, D & Fraser, RB 1999, 'Strategies for coping with labour: does antenatal education translate into practice?', *Journal of Advanced Nursing*, vol.29, no.2, pp.388–94.

Spinelli, A, Baglio, G, Donati, S, Grandolfo, ME, Osborn, J 2003, 'Do antenatal classes benefit the mother and her baby?' *J Matern Fetal Neonatal Medical*, vol.13, no.94–101.

Stacy, RD 2008, 'Evaluation of the Use of a Parent-Held Child Health Record by Pregnant Women and Mothers of Young Children', *Californian Journal of Health Promotion*, vol.6, no.1, pp.138-142.

Starrock, WA & Johnson, JA 1990, 'The relationship between childbirth education classes and obstetric outcome', *Birth*, vol.17, no.2, pp.82–85.

Stein, A, Gath, DH, Bucher, J, Bond, A, Day, A & Cooper, PJ 1991, 'The relationship between post-natal depression and mother-child interaction', *British Journal of Psychiatry*, 158, 46-52.

Stetler, CB, Brunell, M, Giuliano K, Morsi D, Prince, L & Newell-Stokes, G 1998, 'Evidence based practice and the role of nursing leadership', *Journal of Nursing Administration*, vol.8, pp.45–53.

Street, AF 1992, *A critical ethnography of clinical nursing practice*, New York: State University of New York Press.

- Strumpfer, DJW 2006, 'The strengths perspective: fortigenesis in adult life', *Soc Indic Res.* 2006, vol.77, no.1, pp.11–36.
- Sturgeon, S 2007, 'Promoting mental health as an essential aspect of health promotion', *Health Promotion International*, vol. 21, no.S1. pp.36-41.
- Sullivan, A, Raynor, M & Oates, M 2003, 'Why mothers die: perinatal mental health', *British Journal of Midwifery*, vol.11, pp.310-12.
- Svedberg, P 2011, 'In what direction should we go to promote health in mental health care?', *Int J Qualitative Stud Health Well-being*, vol. 6, 7118 - DOI: 10.3402/qhw.v6i2.7118.
- Teti, DD, Gelfand, CM, Messinger, DS & Isabella, R 1995, 'Maternal depression and the quality of early attachment: An examination of infants, preschoolers, and their Mothers', *Developmental Psychology*, vol.31, pp.364-376.
- Taylor, GW & Ussher, JM 2001, 'Making sense of S&M: A discourse analytic account', *Sexualities*, vol.4, no.3, pp.293-314.
- Thomas, J 1983, 'Chicago sociology: An introduction', *Urban life*, 11, 387-395.
- Thomas, J 1993, *Doing critical ethnography*, Newbury Park, CA: Sage.
- Thomas, J & O'Maolchatha, A 1989, 'Reassessing the critical metaphor: and optimistic revisionist view', *Justice Quarterley*, vol. 6, no.2, pp.143-172.
- Tovey, P & Adams, J 2003, 'Nostalgic and nostophobic referencing and the authentication of nurses' use of complementary therapies'. *Social Science & Medicine*, vol.56, pp.1469–1480.
- Van, HM 1996, 'Challenges to identifying and treating women with depression in rural primary care', *Social Work in Health Care*, vol.23, pp.73–92.
- Vandenberg, H & Hall, W 2011, 'Critical ethnography: extending attention to bias and reinforcement of dominant power relations', *Nurse Researcher*, vol.18, no.3, pp.25-30.

Victorian Government 2006, '*Evaluation of Victorian Maternal and Child Health Service*', Department of Human Services, Early Years Services, Office of Children.

Victorian Government's Department of Education and Early Childhood Development 2010, *Child Health Record Literature Review*, Centre for Community Child Health Murdoch Childrens Research Institute.

VicHealth 1999, '*Mental health promotion plan foundation document 1999-2002*', Carlton, Australia, Victorian Health Promotion Foundation.

Victorian Parenting Centre, 2005, C-Frame parenting skills development framework <http://www.parentingrc.org.au/vp/projects/projectview.php?id=20>

Weiner, L 1994, 'Reconstructing motherhood: La Leche League in postwar America', *Journal of American History*, vol.80, pp.1357-1381.

Werner, D 1984, 'The life and death of primary health care', *Tambalan*, January-April, vol.7, p.19-21.

Werner, D & Sanders, D 1997, 'Questioning the solution: The politics of Primary Health Care and Child Survival', Palo Alto, *HealthWrights*, pp.23-25.

Whitehead, D 2001, 'Health education, behavioural change and social psychology: nursing's contribution to health promotion?' *Journal of Advanced Nursing*, vol.34, pp.822-832.

Whitehead, D 2003, 'Health promotion and health education viewed as symbiotic paradigms: Bridging the theory and practice gap between them', *Journal of Clinical Nursing*, vol.12, pp.796-805.

Whitehead, D 2008, 'An international Delphi study examining health promotion and health education in nursing practice, education and policy', *Journal of Clinical Nursing*, vol. 17, pp. 891-900.

Whitehead, D 2009, 'Health promotion in nursing: a Derridean discourse analysis', *Health Promotion International*, vol. 26 no.1, pp.117-127.

Wickberg, B 2000, 'The role of the Child Health Services in promoting mental health: an introduction', *Acta Paediatrica*, vol.89, no. Supplement s434, pp.33–36.

Willis, E 1983, *Medical dominance: The division of labour in Australian healthcare*, Sydney, Allen and Unwin.

Willis, E 2006, 'Introduction: Taking stock of medical dominance', *Health Sociology Review*, vol. 15, p.421-431.

Wilson, HV 2001, 'Power and partnership: a critical analysis of the surveillance discourses of child health nurses', *Journal of Advanced Nursing*, vol. 36, pp.294–301.

Wolman, WL, Chalmers, B, Hofmeyr, J 1993, 'Postpartum depression and companionship in the clinical birth environment: A randomized, controlled study', *American Journal of Obstetrics and Gynaecology*, vol.168, pp.1388–1393.

World Health Organisation 1978, *Declaration of Primary Health Care at Alma-Ata*.

World Health Organisation (WHO) and Canadian Public Health Association, *Ottawa Charter for Health Promotion*. Ottawa: International Conference on Health Promotion, 1986 Nov 17–21.

World Health Organization (WHO) 2001, *Mental Health: strengthening mental health Promotion*.

World Health Organization (WHO) 2004, *Promoting Mental Health: Summary Report*.

World Health Organisation (WHO) 2013, *Mental health action plan 2013-2020*.

Yelland, J, McLachlan, H, Forster, D, Rayner, J, Lumley, J 2006. 'How is maternal psychosocial health assessed and promoted in the early postnatal period?', *Midwifery*, vol. 23, pp.287–297.

Yelland, JS, McLachlan, H, Forster, D, Rayner, J, & Lumley, J 2007, 'How is maternal psychosocial health assessed and promoted in the early postnatal period? Findings from a review of hospital postnatal care in Victoria, Australia', *Midwifery*, vol.23, pp.287–297.

Yelland, S, Sutherland, GA, Wiebe, JL & Brown, SJ 2009, 'A national approach to perinatal mental health in Australia: exercising caution in the roll-out of a public health initiative', *MJA*, vol.191, pp.276–279.

Young, E 2008, 'Maternal expectations: do they match experience?', *Community Practitioner*, Oct, vol.81, no.10, pp.27.

Zerwekh, JV 1992, 'Laying the ground work for family self help: locating families, building trust and building strengths', *Public Health Nursing*, vol.9, no.1.

Zwelling, W 1996, 'Childbirth education in the 1990s and beyond', *Journal of Obstetric, Gynaecologic, and Neonatal Nursing*, vol.25, pp.425-432.

Appendix 1

Letters of Support

Department of Health and Human Services



**WOMEN'S & CHILDREN'S
SERVICES**

Contact: Sue McBeath
Phone: 03 6348 8972
Facsimile: 03 6348 8973
E-mail: sue.mcbeath@dhhs.tas.gov.au
File:

To whom it may concern

RE: Robyn Kelly PhD candidate 'Early Parenting Mental Health Promotion'

I am writing a letter of support for Robyn's request to

1. Access Perinatal parenting class curricula from within the Women's and Children's Health services within NAHS and
2. Act as a conduit for emails to WACS staff for recruitment for focus groups and interviews.

Robyn is undertaking a study that will explore early parenting health professionals' understanding of mental health promotion and examine antenatal and postnatal education curricula for mental health promotional themes/content throughout Tasmania. She aims to be able to inform WACS policy and/or curricula development with her findings.

This will be a very worthwhile project for the Tasmanian community.

As this is an important area for midwifery services, I am therefore happy to support this proposal on behalf of the WACS NAHS and to liaise with Robyn throughout the project and to work with her at the completion of her studies.

Yours sincerely,

Sue McBeath
Co-Director
(Nursing & Midwifery)
Women's & Children's Services
Launceston General Hospital

9 September 2010

Women's & Children's Services, Level 4 Launceston General Hospital, PO Box 1963, Launceston Tasmania 7250



Department of Health and Human Services

ROYAL HOBART HOSPITAL

GPO Box 1061
Hobart, TASMANIA 7001
Ph (03) 6222 8308

Contact: Women's & Children's Clinical Services
Phone: (03) 6222 8676
Facsimile: (03) 6222 8028
E-mail: michael.yates@dhhs.tas.gov.au



To Whom It May Concern:

RE: Robyn Kelly PhD Candidate for Early Parenting Mental Health Promotion

This letter is to support Robyn Kelly's request to seek ethics approval for research study into Perinatal Mental Health Promotion.

Robyn's extensive history of study includes the commencement of a Master in International Health (Primary Health Care). The thesis for this study included a systematic literature review regarding antenatal parenting education curricula. Robyn also analysed a theoretical framework seeking to incorporate parenting stressor identification including risk and protective factors associated with Postnatal Depression.

Robyn's study determined the following needs:

1. To explore early parenting health professionals' understanding of mental health promotions.
2. To further investigate antenatal and postnatal education curricula throughout Tasmania which is delivered by DHHS midwives and Child Health nurses to parents within the perinatal period.

Robyn has expressed an eagerness to continue her study into this important area in midwifery services and I fully support her application and happy to assist in facilitating the successful completion of her project.

Yours sincerely ,

Michael Yates
A/Nursing & Services Director
Women's & Children's Clinical Services

24 September 2010

Department of Health and Human Services

NORTH WEST AREA HEALTH SERVICE

GPO Box 125, HOBART TAS 7001, Australia

Ph: (03) 6233 3185 Fax: (03) 6233 4021

Web: www.dhhs.tas.gov.au



Contact: Karen O'Shea
Phone: (03) 6426 5469
Facsimile: (03) 6426 5441
E-mail: karen.oshea@dhhs.tas.gov.au
File:

To whom it may concern

Subject: Robyn Kelly PhD candidate 'Early Parenting Mental Health Promotion'

I am writing a letter of support for Robyn's request for 1) access to perinatal parenting class curricula from within the Women and Children's Health services within NWAHS and 2) to act as a conduit for emails to WACS staff for recruitment for focus groups and interviews.

Robyn is undertaking a study that will explore early parenting health professionals' understanding of mental health promotion and examine antenatal and postnatal education curricula for mental health promotional themes/content throughout Tasmania. She aims to be able to inform WACS policy and/or curricula development with her findings.

This will be a very worth while project for the Tasmanian community.

As this is an important area for midwifery services, I am therefore happy to support this proposal on behalf of the WACS NWAHS and to liaising with Robyn throughout the project and to working with her at the completion of her studies.

Karen O'Shea
Co Director Women's and Children's Services

26 August 2010

Department of Health and Human Services
CHILD HEALTH AND PARENTING SERVICE

L1, 13 Mulgrave Street, Launceston, Tasmania 7250
Ph: (03) 6336 2138 Fax: (03) 6336 2133
Web www.dhhs.tas.gov.au



Contact: Christine Long
E-mail: christine.long@dhhs.tas.gov.au

To whom it may concern

Re: Robyn Kelly PhD Candidate for Early Parenting Mental Health Promotion

Child Health and Parenting Service fully support Robyn Kelly's request for ethics approval for research into the perinatal promotion of mental health with parents.

Robyn's research will be timely and the CHAPS (area) Managers and I will be happy to facilitate access to relevant Child Health and Parenting Service curricula e.g. service delivery models, practice protocols and the Personal Health Record or 'blue book' given out to all Tasmanian parents on the birth of their child. We will also do what we can to facilitate Robyn making contact with health professionals within our service.

Yours sincerely

Christine Long
Director of Nursing

1 October 2010

Appendix 2

Ethics application approval letter

Social Science Ethics Officer
Private Bag 01 Hobart
Tasmania 7001 Australia
Tel: (03) 6226 2764
Fax: (03) 6226 7148
Marilyn.Knott@utas.edu.au



HUMAN RESEARCH ETHICS COMMITTEE (TASMANIA) NETWORK

08 November 2010

Professor Denise Fassett
Nursing and Midwifery
Private Bag 1322
Launceston Tasmania

Dear Professor Fassett

Re: MINIMAL RISK ETHICS APPLICATION APPROVAL
Ethics Ref: **H0011516 - Early Parenting Mental Health Promotion.**

Acting on a mandate from the Tasmania Social Sciences HREC, the Chair of the committee considered and approved the above project on 08 November 2010.

Please note that this approval is for four years and is conditional upon receipt of an annual Progress Report. Ethics approval for this project will lapse if a Progress Report is not submitted.

The following conditions apply to this approval. Failure to abide by these conditions may result in suspension or discontinuation of approval.

1. It is the responsibility of the Chief Investigator to ensure that all investigators are aware of the terms of approval, to ensure the project is conducted as approved by the Ethics Committee, and to notify the Committee if any investigators are added to, or cease involvement with, the project.
2. Complaints: If any complaints are received or ethical issues arise during the course of the project, investigators should advise the Executive Officer of the Ethics Committee on 03 6226 7479 or human.ethics@utas.edu.au.
3. Incidents or adverse effects: Investigators should notify the Ethics Committee immediately of any serious or unexpected adverse effects on participants or unforeseen events affecting the ethical acceptability of the project.
4. Amendments to Project: Modifications to the project must not proceed until approval is obtained from the Ethics Committee. Please submit an Amendment Form (available on our website) to notify the Ethics Committee of the proposed modifications.

A PARTNERSHIP PROGRAM IN CONJUNCTION WITH THE DEPARTMENT OF HEALTH AND HUMAN SERVICES

5. Annual Report: Continued approval for this project is dependent on the submission of a Progress Report by the anniversary date of your approval. You will be sent a courtesy reminder closer to this date. **Failure to submit a Progress Report will mean that ethics approval for this project will lapse.**
6. Final Report: A Final Report and a copy of any published material arising from the project, either in full or abstract, must be provided at the end of the project.

Yours sincerely

Ethics Executive Officer

Appendix 3

a) Participant information letter



PARTICIPANT INFORMATION SHEET School of Nursing and Midwifery

Early Parenting Mental Health Promotion

Invitation

You are invited to participate in a research study that is exploring how early parenting health professionals understand mental health promotion.

The study is being conducted within the School of Nursing and Midwifery at UTAS by PhD student Robyn Kelly, a registered midwife and child health nurse, and is in partial fulfillment of the degree of Doctor of Philosophy under the supervision of the Chief investigator for this study, Professor Denise Fassett (UTAS School of Nursing and Midwifery) and Co-Investigator Professor Yvonne Hauck (Curtin University, Western Australia).

1. 'What is the purpose of this study?'

This study aims to explore how midwives and child health nurses understand the term 'mental health promotion'.

2. 'Why have I been invited to participate in this study?'

You are eligible to participate in this study because you work with parents within the perinatal period.

3. 'What does this study involve?'

This study aims to explore your thoughts around early parenting mental health promotion and will take the form of a semi-structured interview. Robyn will ask a set of open questions and the discussion between you and her surrounding these questions will be audio recorded. *It is envisaged that the interview will take between one to two hours of your time.* It is important that you understand that your involvement in this study is voluntary. While we would be pleased to have you participate, we respect your right to decline. If you decide to discontinue participation at any time, you may do so without providing an explanation.

All information will be treated in a confidential manner, and neither your name nor for whom you work will be used in any publication arising out of the research. The audio recording and any notes that Robyn makes during the interview will be kept in a locked cabinet in the Chief Investigator's office within the School of Nursing and Midwifery. Please also note that 5 years post publication, all electronic files of your information will be destroyed by deletion with audio files being erased, and transcripts and any written notes that have been made will be shredded at UTAS.

5. Are there any possible benefits from participation in this study?

It is an aim of this study to inform perinatal educational curricula regarding mental health promotion partially from data collected during the interviews with early parenting health professionals. The study could also have implications for funding into expanding service provision within the parenting services.

6. Are there any possible risks from participation in this study?

There are no specific risks anticipated with participation in this study. Information discussed during the interviews will be de-identified for people and institutions named.

7. What if I have questions about this research?

If you would like to discuss any aspect of this study please feel free to contact Robyn Kelly on ph (03) 6324 3671 or email her at Robyn.Kelly@utas.edu.au.

This study has been approved by the Tasmanian Social Science Human Research Ethics Committee. If you have concerns or complaints about the conduct of this study should contact the Executive Officer of the HREC (Tasmania) Network on (03) 6226 7479 or email human.ethics@utas.edu.au. The Executive Officer is the person nominated to receive complaints from research participants. You will need to quote [11516].

**Thank you for taking the time to consider this study.
If you wish to take part in it, please sign the attached consent form.**

This information sheet is for you to keep.

b) Participant information consent form



CONSENT FORM

Early Parenting Mental Health Promotion

1. I have read and understood the 'Information Sheet' for this project.
2. The nature of the study has been explained to me.
3. I understand that the study involves me taking part in an hour long semi-structured interview regarding my thoughts about mental health promotion in early parenting.
4. I understand that all research data will be securely stored on the University of Tasmania premises for five years and will then be destroyed.
5. Any questions that I have asked have been answered to my satisfaction.
6. I agree that research data gathered from me for the study may be published provided that I cannot be identified as a participant.
7. I understand that the researchers will maintain my identity confidential and that any information I supply to the researcher(s) will be used only for the purposes of the research.
8. I agree to participate in this investigation and understand that I may withdraw at any time without any effect, and if I so wish may request that any data I have supplied to date be withdrawn from the research.

Name of Participant: _____

Signature: _____

Date: _____

Statement by Investigator

☐

I have explained the project & the implications of participation in it to this volunteer and I believe that the consent is informed and that he/she understands the implications of participation

If the Investigator has not had an opportunity to talk to participants prior to them participating, the following must be ticked.

☐

The participant has received the Information Sheet where my details have been provided so participants have the opportunity to contact me prior to consenting to participate in this project.

Name of Investigator _____

Signature of Investigator _____

Name of investigator _____

Signature of investigator _____ Date _____